

North Carolina's Medicaid Managed Care Quality Strategy

April 18, 2019

Table of Contents

I. Introduction and Overview	4
(A) History of Medicaid Managed Care in North Carolina	4
(B) Quality Strategy Aims, Goals, Objectives, and Measures	7
(C) Development and Review Of The Quality Strategy	13
II. Improvements and Interventions	15
(A) PHP Quality Assessment and Performance Improvement Programs	15
(B) DHHS Quality Management and Improvement Structure	17
(C) Interventions	18
(1) Opioid Strategy	19
(2) Healthy Opportunities Strategy	20
(3) Advanced Medical Homes (AMHs)	21
(4) Managing High-Risk Pregnancies	22
(5) Care Management for At-Risk Children	23
(6) Behavioral Health Integration	23
(7) Provider Supports	23
(9) Value-Based Payment (VBP)	24
(10) Centers for Disease Control and Prevention (CDC) 6 18 Initiative	24
(11) Accreditation	25
(12) Health Equity Reporting and Tracking	25
(D) Health Information Technology	25
III. State Standards for Access, Structure, and Operations	26
(A) State Access Standards	26
(1) Network Adequacy Standards	26
(2) Availability of Services	34
(3) Access to Care During Transitions of Coverage	35
(4) Assurances of Adequate Capacity and Services	36
(5) Coordination and Continuity of Care	37
(6) Coverage and Authorization of Services	38
(B) Structure and Operations Standards	39
(1) Provider Selection	39
(2) Practice Guidelines	39
(3) Enrollee Information	40
(4) Enrollment and Disenrollment	42
(5) Confidentiality	44
(6) Grievance and Appeals Systems	44
(7) Sub-Contractual Relationships and Delegation	45
(8) PHP Health Information Technology	46
IV. Assessment	46
(A) Assessment of Quality and Appropriateness of Care	46
(B) Monitoring and Compliance of PHP Access, Structure, and Operations	49
(C) Use of Sanctions	51
V. Conclusion and Opportunities	52

Table of Contents (continued)

Appendices	55
Appendix A: Priority Quality Performance Measures.....	55
Appendix B: External Quality Review Organization (EQRO) Activities.....	62
Appendix C: Minimum Required Elements of PHPs’ Annual Fraud Prevention Plans and Reports.....	64

I. Introduction and Overview

(A) History of Medicaid Managed Care in North Carolina

North Carolina's Medicaid and NC Health Choice programs provide health coverage to approximately two million North Carolinians, including coverage for over one in two births and two in five children.¹ Nearly 60 percent of the State's Medicaid beneficiaries are under the age of 21, and nearly 58 percent are female.²

Today, North Carolina has separate payment and delivery systems for physical health services and behavioral health and intellectual/developmental disabilities (I/DD) services. Physical health services are delivered through fee-for-service and managed through DHHS' Primary Care Case Management (PCCM) program, while behavioral health and I/DD services are delivered by local management entity-managed care organizations (LME-MCOs), further described below. Starting on November 1, 2019 and as mandated under NC Session Law 2015-245, the Department of Health and Human Services (the Department) will transition most beneficiaries into fully capitated managed care plans, called Prepaid Health Plans (PHPs).

North Carolina has a strong record of investment in innovative programs, managing cost growth, boasts high rates of beneficiary participation in primary care medical homes, and enjoys strong provider participation with over 65,000 enrolled providers. In implementing managed care, North Carolina is building upon its successes to achieve even more – innovating and evolving to improve the health of North Carolinians.

This Quality Strategy aims to guide North Carolina's managed care implementation efforts by establishing clear Aims, Goals, and Objectives to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions, and details the standards and mechanisms for holding managed care entities accountable for desired outcomes. The Quality Strategy is a roadmap through which the Department will use managed care infrastructure to facilitate improvements in health and health care through programmatic innovations, whole-person care, provider supports, and steps to address health-related unmet resource needs.

Development of Managed Behavioral HealthCare through the LME-MCOs

In 2005, the North Carolina Department of Health and Human Services (the Department) implemented a concurrent 1915(b)/(c)³ Medicaid waiver to establish managed behavioral health and I/DD care through LME-MCOs. The LME-MCO concept was initially designed as a pilot project to serve Medicaid beneficiaries with mental health, developmental disabilities and substance abuse needs in a limited catchment area. The pilot LME-MCO also delivered home- and community-based services and supports through the Innovations waiver, a 1915(c) home and community-based services waiver for individuals with intellectual/developmental disabilities. In 2009, the Department elected to expand the 1915 (b)/(c) Medicaid waiver statewide and initiated a collaborative effort between the North Carolina Division of

¹ Kaiser Family Foundation. Medicaid State Fact Sheets. North Carolina. <http://files.kff.org/attachment/fact-sheet-medicaid-state-NC>

² Medicaid and NC Health Choice Annual Report for State Fiscal Year 2016. Available at:

<https://files.nc.gov/ncdha/documents/files/Medicaid-Annual-Report-State-Fiscal-Year-2016.pdf>

³ The waiver that allowed the Department to restructure the management responsibilities for the delivery of services to individuals with mental illness, intellectual and other developmental disabilities, and substance use disorders through managed care arrangements with local management entity-managed care organizations (LME-MCOs).

Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The goal was to restructure the delivery system for Medicaid and state-funded mental health, substance abuse, and intellectual/developmental disabilities services.⁴ Currently, DHHS contracts with LME-MCOs, which act as capitated prepaid inpatient health plans (PIHPs), to operate Medicaid-funded services in different regions of the State.

Broader Transition to Managed Care

In September 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of the State's Medicaid program from a predominately fee-for-service structure to a capitated managed care structure. Since that time, the Department has worked with the General Assembly and stakeholders to plan the implementation of this directive. The Department is committed to transitioning North Carolina to Medicaid managed care in a way that advances high-value care, improves population health, engages and supports beneficiaries and providers, and establishes a sustainable program with predictable costs.

Specifically, the Department has identified as high priorities: advancing whole-person care so that all plans will include physical health, mental health, and substance use services for beneficiaries; addressing unmet health-related resource needs (sometimes called the “social determinants of health” or “healthy opportunities”); and enhancing local, community-based care management, as well as other interventions described in more detail throughout this Quality Strategy. At the core of these efforts is the goal of improving the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care that addresses both medical and non-medical drivers of health.

Populations Included in Managed Care

Starting in November 2019, most Medicaid and NC Health Choice populations will be enrolled in managed care. These populations will be enrolled in PHPs to receive integrated physical health, behavioral health, and pharmacy services at the launch of the managed care program.

Populations Not Initially Included in Managed Care Enrollment

There are limited exceptions to mandatory enrollment for certain populations that may be better served outside of managed care. These populations are either *exempt* (meaning they may choose, but are not required, to enroll in Medicaid managed care) or *excluded* (meaning they must remain enrolled in fee-for-service and may not enroll in managed care). In addition, certain populations will be delayed in their enrollment, allowing for additional time to conduct thoughtful planning and a smooth transition to managed care. Notably, populations with significant behavioral health needs, I/DDs, or traumatic brain injury that meet criteria established by the Department will be delayed in enrolling in PHPs until July 2021, when the Department will launch behavioral health and I/DD tailored plans—specialized managed care products targeted towards the needs of these populations. Excluded, exempt and delayed populations are described in Figure 1 below.

⁴ The statewide expansion was authorized by the General Assembly in 2011 in Session Law 2011-264, available at <http://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2011-2012/SL2011-264.html>

Figure 1. Populations Exempt, Excluded and Delayed from Managed Care

Exempt Populations	
<ul style="list-style-type: none"> Members of federally recognized tribes⁵ 	
Excluded Populations	
<ul style="list-style-type: none"> Program of All-Inclusive Care for the Elderly (PACE) beneficiaries Medically needy beneficiaries (also known as “Spend Down”) except for those enrolled in the Innovations, and Traumatic Brain Injury (TBI) waivers, Medicaid-only CAP/C and CAP/DA waiver beneficiaries Beneficiaries only eligible for emergency services Presumptively eligible beneficiaries, during the period of presumptive eligibility Health Insurance Premium Payment (HIPP) beneficiaries, except for those enrolled in the Innovations and TBI waivers Family planning beneficiaries Prison inmates 	
Delayed Populations ⁶	
Special Populations	Expected Phase-In Timeline (no earlier than):
<ul style="list-style-type: none"> Certain Medicaid and NC Health Choice beneficiaries with an SMI, SED, SUD or I/DD diagnosis and those enrolled in the TBI waiver⁷ 	<ul style="list-style-type: none"> July 2021
<ul style="list-style-type: none"> Foster Children 	<ul style="list-style-type: none"> July 2021
<ul style="list-style-type: none"> Medicaid-only beneficiaries receiving long-stay nursing home services 	<ul style="list-style-type: none"> No sooner than 5 years after managed care implementation
<ul style="list-style-type: none"> Individuals who are dually-eligible for Medicare and Medicaid 	<ul style="list-style-type: none"> No sooner than 5 years after managed care implementation

Additional information on this transition is available in *North Carolina’s Proposed Program Design for Medicaid Managed Care and North Carolina’s Amended Waiver Application*.⁸

Linking Quality Strategies for Special Populations During the Transition

⁵ North Carolina consulted with its only federally-recognized tribe – the Eastern Band of Cherokee Indians (EBCI) – and concluded that tribal members will benefit from having the option to enroll in a PHP. The Department is also working with the EBCI to develop a model under which the EBCI would form an Indian Managed Care Entity to assume responsibility for managing care for EBCI members and other individuals eligible to receive IHS services – referred to as the “Tribal Option.” The Department will work with the General Assembly on the changes necessary to allow the EBCI to implement the Tribal Option. Current estimates indicate there are approximately 4,000 EBCI members enrolled in Medicaid.

⁶ NC Session Law 2015-245 as amended by NC Session Law 2018-48 and Session Law 2018-49 authorizes the delayed mandatory enrollment of certain Medicaid and NC Health Choice beneficiaries with an SMI, SED, SUD or I/DD diagnosis and those enrolled in the TBI waiver; Medicaid-only beneficiaries receiving long-stay nursing home services; and Individuals who are dually-eligible for Medicare and Medicaid. Currently, these sessions laws exclude Medicaid-only CAP/C and CAP/DA waiver beneficiaries from managed care, and their delayed mandatory enrollment is contingent on approval by the General Assembly.

⁷ Individuals who are dually eligible for Medicare and Medicaid and have an SMI, SED, SUD or I/DD or are enrolled in the Innovations or TBI waiver will enroll in managed care in July 2021 for their Medicaid-covered BH and I/DD services only.

⁸ North Carolina’s Proposed Program Design for Medicaid Managed Care, August 2017. Available Online at: https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf

This Quality Strategy focuses on measuring quality performance and outcomes in the early years of managed care, affecting the populations that will transition to managed care immediately (outlined above); it will expand to capture additional populations as they are brought into managed care over time. During the transition, North Carolina will continue to operate LME-MCOs, which will provide behavioral health and I/DD services to populations excluded or delayed from mandatory enrollment in PHPs at launch. LME-MCOs will continue to administer the Innovations and TBI waivers, and the fee-for-service Medicaid program will continue to run the CAP/C and CAP/DA waivers. During this time of transition, the quality measures and requirements for each of these special programs and for LME-MCOs will remain in place, and all State Medicaid programs will be focused on the unifying Aims outlined in the section that follows.

Quality requirements associated with the CAP/C and CAP/DA waivers are available online:

- [CAP/C Waiver](#)
- [CAP/DA Waiver](#)

(B) Quality Strategy Aims, Goals, Objectives, and Measures

North Carolina’s Quality Strategy is built around the drive to build an innovative, whole-person, well-coordinated system of care, which addresses both medical and non-medical drivers of health and promotes health equity. This vision is distilled into three central Aims:

(1) Better Care Delivery

(2) Healthier People, Healthier Communities

(3) Smarter Spending

Included within each of these three Aims is a series of Goals and Objectives, intended to highlight key areas of expected progress and quality focus. Together, as is shown in Figure 3 below, these Aims, Goals, and Objectives create a framework through which North Carolina defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in the state. These Aims and Goals were designed to align closely with [CMS’s Quality Strategy](#), adapted to address local priorities, challenges, and opportunities for North Carolina’s Medicaid program.

Figure 2. North Carolina’s Quality Strategy Aims, Goals and Objectives

Aims	Goals	Objectives
Aim 1: Better Care Delivery. <i>Make health care more person-centered, coordinated and accessible.</i>	Goal 1: Ensure appropriate access to care	Objective 1.1: Ensure timely access to care
		Objective 1.2: Maintain Medicaid provider engagement
	Goal 2: Drive patient-centered, whole person care	Objective 2.1: Promote patient engagement in care
		Objective 2.2: Link patients to appropriate care management and care coordination services
		Objective 2.3: Address behavioral and physical health comorbidities

Aims	Goals	Objectives
Aim 2: Healthier People, Healthier Communities. <i>Improve the health of North Carolinians through prevention, better treatment of chronic conditions, and better behavioral health care, working collaboratively with community partners.</i>	Goal 3: Promote wellness and prevention	Objective 3.1: Promote child health, development, and wellness
		Objective 3.2: Promote women's health
		Objective 3.3: Maximize long term services and supports (LTSS) populations' quality of life
	Goal 4: Improve chronic condition management	Objective 4.1: Improve behavioral health care
		Objective 4.2: Improve diabetes management
		Objective 4.3: Improve asthma management
		Objective 4.4: Improve hypertension management
	Goal 5: Work with communities to improve population health	Objective 5.1: Address unmet resource needs
		Objective 5.2: Address the opioid crisis
		Objective 5.3: Address tobacco use
		Objective 5.4: Reduce health disparities
		Objective 5.5: Address obesity
Aim 3: Smarter Spending <i>Pay for value rather than volume, incentivize innovation and ensure appropriate care.</i>	Goal 6: Pay for value	Objective 6.1: Ensure high-value, appropriate care

Development of the Quality Strategy Aims, Goals, and Objectives

These Goals and Objectives reflect significant community and stakeholder input as well as thoughtful consideration of the quality issues that are most important in North Carolina. The Department contracted with the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics (or, the “NCIOM Task Force”) to convene stakeholders across the state to issue recommendations on the specific quality metrics North Carolina Medicaid should focus on during and throughout the transition to managed care. The NCIOM Task Force brought together a statewide group of providers, beneficiaries, quality experts, and managed care plan representatives who recommended a set of Medicaid quality measures to be used to drive improvement in the health of Medicaid beneficiaries.⁹ This Quality Strategy and its Objectives recognize that significant process, and are aligned closely with the measures the NCIOM Task Force put forth.

The Department additionally considered the quality areas of greatest importance to the North Carolina Medicaid population, and where current data indicated an opportunity for targeted improvement. The Objectives set forth are similarly aligned to ensuring beneficiary access to services, particularly in the context of the State's transition to managed care. For example:

⁹ Available at: <http://nciom.org/metrics-to-drive-improvements-in-health-a-report-of-the-task-force-on-health-care-analytics/>

- Objective 1.2 (maintain Medicaid provider engagement) under **Goal 1** (ensure appropriate access to care) recognizes the need to maintain North Carolina’s historically high rate of provider participation in Medicaid to fully meet beneficiaries’ needs, including convenient access to the appropriate range of providers in a timely manner.
- Objectives related to **Goal 2** (drive patient-centered, whole-person care) seek to ensure that beneficiaries are engaged in their health care and are satisfied with their PHP, in addition to ensuring that they are linked to an Advanced Medical Home (AMH) provider, described further in Section II(C).
- The objectives aligned to **Goal 3** (promote wellness and prevention) reflect a continued emphasis on improving the health of children and women – populations that represent, respectively, 60 percent and 58 percent of Medicaid beneficiaries in the State as of 2016.¹⁰
- Objectives related to **Goal 4** (improve chronic condition management) focus on conditions that heavily impact the North Carolina Medicaid population, including asthma, diabetes, behavioral health, and hypertension. While other chronic conditions were additionally considered for inclusion, the Department sought to focus on select, targeted priorities that allow for demonstrable progress, reinforced by the NCIOM Task Force’s recommendations and of relevance to existing and newly covered populations in managed care.
- Multiple Objectives tie to **Goal 5** (work with communities to improve population health); these Objectives emphasize areas where community engagement will be critical to advancing a high-quality health system, such as meeting unmet resource needs and combating the opioid epidemic. These Objectives recognize and build upon the progress that has been made at a local level throughout the State.
- Behavioral health is elevated in multiple places throughout these Objectives, in recognition of the complexity of delivering high-quality care for populations with behavioral health needs, and the prevalence and cost of coexisting behavioral and physical health disorders.
- Similarly, the Quality Strategy highlights a key Objective related to populations with LTSS needs; most quality Objectives and measures in this Quality Strategy apply to populations with LTSS needs enrolled in PHPs.

Each of the 18 Objectives are tied to a series of focused interventions (described in detail in Section II(C)) used to drive improvements within, and in many cases across, the Goals and Objectives set forth in this Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR 438.340(b)(2), these interventions are tied to a set of metrics by which progress is assessed.

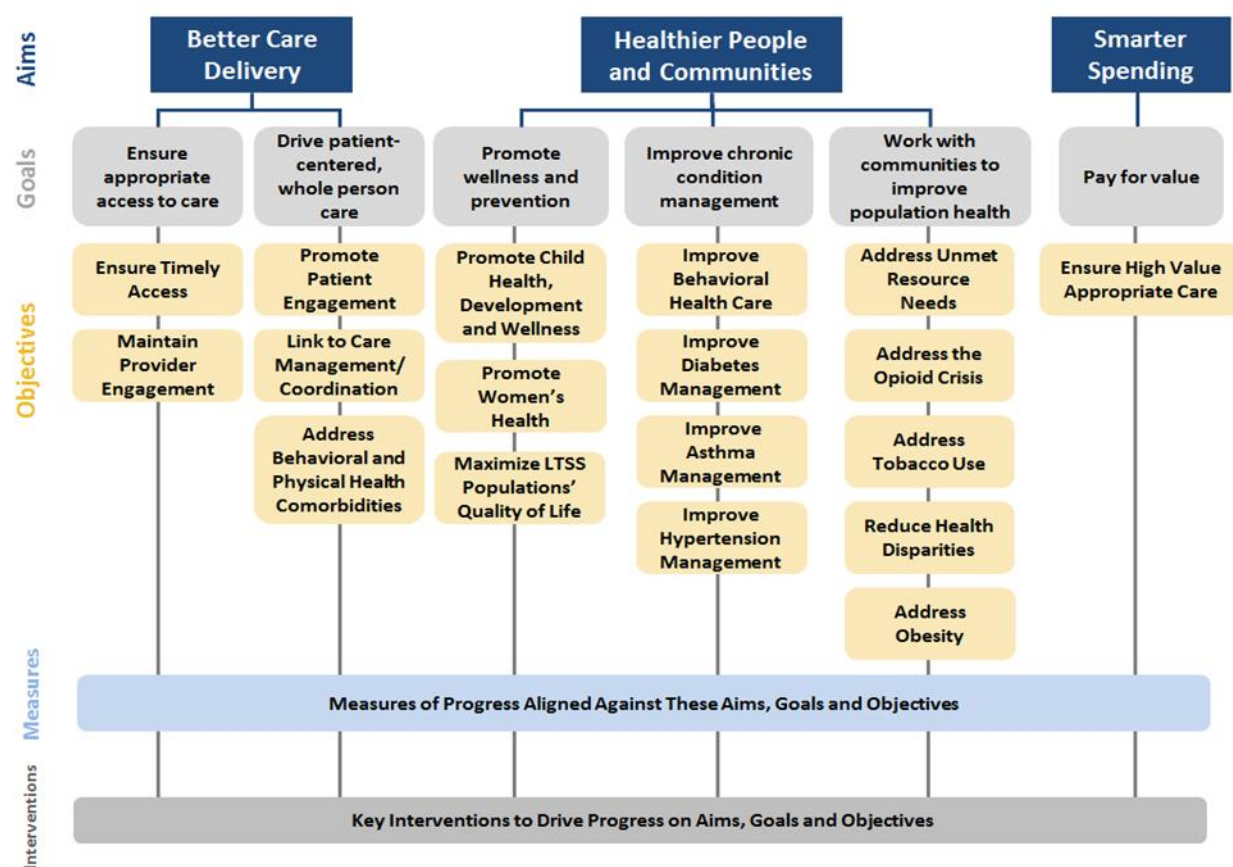
As baseline data related to PHP performance becomes available, the Department intends to further refine

¹⁰ Medicaid and NC Health Choice Annual Report for State Fiscal Year 2016. Available at: <https://files.nc.gov/ncdma/documents/files/Medicaid-Annual-Report-State-Fiscal-Year-2016.pdf>

these Objectives to target specific improvement goals, including additional metrics that address disparities in health. As described in Section III(B), PHPs are required to maintain systems that collect, analyze, integrate, and report encounter data in a timely, accurate, and complete way. This data is used for several purposes, and will be key to the quality of North Carolina’s Medicaid managed care program, as directly related to quality performance and otherwise. The External Quality Review Organization (EQRO), further discussed in Section IV(A) and Appendix B of this Quality Strategy, will play a critical role in ensuring the validity of PHPs’ reported encounter data, as well as in the validation and calculation of quality measures. the Department is committed to using these reports to assess opportunities for continued improvement, and how priorities may evolve over time and as additional populations are enrolled in managed care.

Together, this framework represents a comprehensive plan for delivering high quality, accessible, timely care to Medicaid managed care beneficiaries (Figure 3).

Figure 3. Overview of the Quality Strategy Framework



Overview of Quality Measures

North Carolina has developed standard performance measures, as required by 42 CFR 438.330(c), that PHPs are required to measure and report to the Department, as outlined below. Consistent with the Department’s desire to benchmark its progress against other states’ performance and assess key priorities to drive

continuous quality improvement efforts, nearly all of these measures are nationally-recognized. For select areas of priority, PHPs are required to report certain administrative and program-specific measures critical to the Department’s ability to comprehensively assess performance against the Goals and Objectives set forth in this Quality Strategy.

DHHS requires PHPs to report in a timely, complete, and accurate manner:

- A select set of additional measures aligned to the Aims, Goals, and Objectives of the Quality Strategy, as identified in Appendix A.
- All HEDIS measures required for NCQA health plan accreditation, regardless of whether the PHP has achieved accreditation to date (PHPs are required to achieve accreditation by Year 3 of operations, as further discussed in Section II(C)(8)); and
- A select set of CMS Adult and Child Core measures, including – at minimum – those outlined in Appendix A of this Quality Strategy and those historically reported to CMS;^{11,12}

In some cases, DHHS may directly report measures using data provided by PHPs linked to data from other sources (for example, Vital Statistics data).

Additionally, and as is further described in Section IV(A), the EQRO provides DHHS with the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey which asks beneficiaries to report on their experiences accessing care.¹³ DHHS requires reporting on beneficiary responses to the Adult 5.0, Children 4.0, Children Chronic Condition Supplemental and Home and Community Based Services (HCBS) CAHPS surveys. DHHS uses these patient-reported measures as part of its evaluation of PHP performance and to consider areas that may require additional focus and prioritization as North Carolina’s program and its beneficiaries’ needs evolve. As other special plans and programs are included in managed care, DHHS will assess the incorporation of special population-targeted quality measures. DHHS will continue reporting a subset of the Adult and Child Core measures to CMS, with the goal of increasing the number of Adult and Child Core measures it reports over time.

In addition to quality measures set forth in this Quality Strategy, DHHS requires that PHPs report across several additional areas, including access (as noted in Section II) and compliance with state standards (as noted in Section IV). DHHS will review these reports for quality assurance and improvement purposes, as is further discussed within Section III and IV of this Quality Strategy.

“Priority” Performance Measures

In addition to DHHS’s continuous quality improvement efforts that evaluate the universe of quality measures outlined above, a focused subset of 31 measures outlined in Appendix A are closely aligned to the Aims, Goals,

¹¹ 2017 annual state reporting for adults and children is available at: <https://data.medicaid.gov/Quality/2017-Child-and-Adult-Health-Care-Quality-Measures/y7g4-qir6/data>.

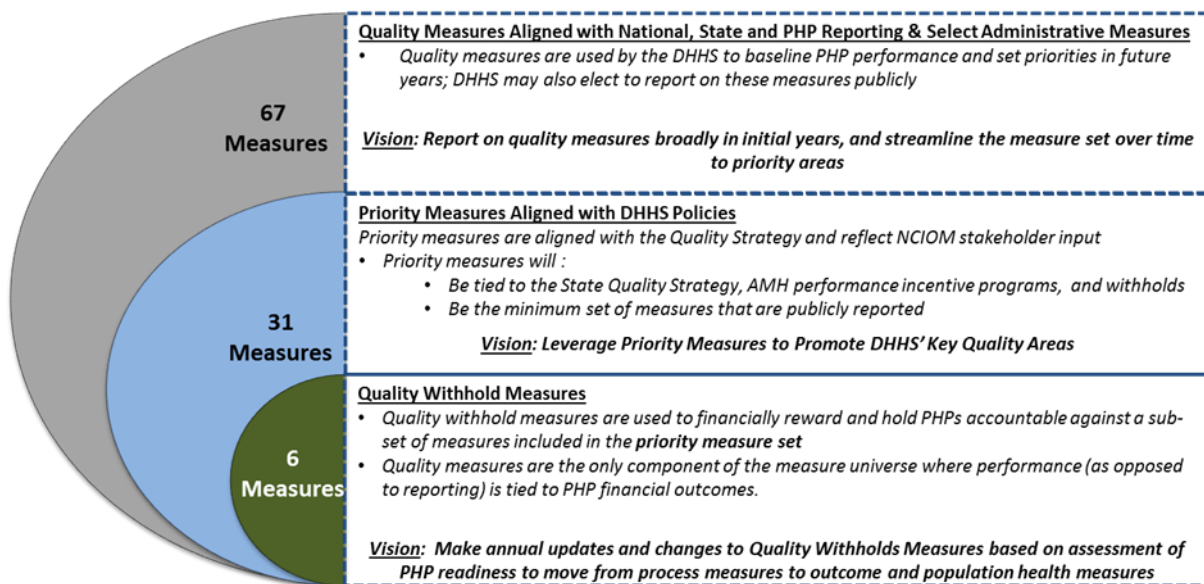
¹² For more information on the Child and Adult Core Set, see: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf>

¹³ For more information on the CAHPS Health Plan Survey, see: <https://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=903&print=0&entityTypeID=1>

and Objectives of this Quality Strategy and will be used to monitor and assess individual and collective PHP progress (Figure 4). This prioritized measure list provides PHPs and other stakeholders with an understanding of the key areas of focus aligned with this Quality Strategy and where DHHS has identified the greatest areas of opportunity and need. This focused set of measures will evolve over time as part of the State’s continuous quality improvement process, and as additional and/or alternate areas of opportunity are identified for prioritization. These measures will serve as the basis for the following efforts:

- The development of an annual publication assessing select measures by relevant strata that may include age, race, ethnicity, sex, primary language, and disability status¹⁴ broken out, where possible, by key population groups (e.g., LTSS, based on aged/blind/disabled status) and geography; and
- The ongoing publication of PHPs’ quality performance on the DHHS website.

Figure 4. Quality and Administrative Measure Reporting Framework



Behavioral Health Measures — Focusing on Integration in Standard Plans

As described above, the State has selected multiple Objectives focused specifically on behavioral health, each of which is tied to select quality measures described in Appendix A. These Objectives and the related measures were selected based on alignment with current State reporting on behavioral health measures (both through LME-MCOs and CMS Adult and Child Core measures) and to reflect emerging best practices from leaders on behavioral health measurement, including the National Quality Forum, the Institute for Healthcare Improvement, the Agency for Healthcare Research and Quality (AHRQ), and the Substance Abuse and Mental Health Services Administration (SAMHSA), among others.

LTSS Measures — Focusing on Quality of Life and Access to Care

¹⁴ Disability status, as set forth by 42 CFR 438.340(b)(6), means whether the individual qualified for Medicaid on the basis of a disability.

As described above, the State has set forth an Objective focused specifically on LTSS populations, which is tied to the quality measures in Appendix A. The LTSS Objective was selected because the Department will review all quality measures against how outcomes differ for LTSS individuals. Specifically, the Department requires that PHPs submit the measures separately for only individuals that have been identified as having an LTSS need as defined by the Comprehensive Assessment. Through analyzing this data, the Department will look to ensure that LTSS individuals have access to care and that plans are made to reduce disparities in treatment outcomes, where possible.

Opioid Measures—Focusing on Drug Monitoring and Substance Abuse Treatment

As described above, the State has set forth an Objective focused on addressing the opioid crisis, and has selected multiple quality measures tied to this Objective. Selected opioid quality measures focus on opioid prescribing patterns, treatment for individuals with substance dependency, and follow-up after substance-related emergency department visits. These measures were selected to encourage both treatment and prevention of opioid addiction, and to align with quality reporting requirements for 2024 set forth in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018. In addition, DHHS has obtained a waiver of the Institution for Mental Diseases (IMD) exclusion to improve access to residential treatment for substance use disorders. As part of the State's implementation and monitoring plan for this waiver, the State will report multiple substance use and opioid-related measures to CMS.

Public Health Measures—Focusing on Tobacco and Diet/Exercise

The State has identified multiple Objectives to advance Goal 5 (work with communities to improve population health). To advance this goal, the State will monitor progress on Healthy NC 2020 measures related to tobacco use and diet and exercise, which address Objectives 5.3 and 5.5, respectively. The State selected tobacco, diet, and exercise as public health measure focus areas for their significant impact on health in North Carolina as well as their potential to be impacted by required PHP activities, such as assistance with tobacco cessation and BMI screening.

(C) Development and Review Of The Quality Strategy

Initial Quality Strategy

A critical element of transitioning North Carolina's Medicaid program from a fee-for-service to managed care structure has been extensive stakeholder involvement and feedback. The initial Quality Strategy was published in March 2018 with a 30 day public comment period, and public comments received on the draft have been incorporated into this version. Prior to publication of the initial draft of this Quality Strategy, the Department also published number of white papers and RFIs and solicited public comment, including *North*

Carolina's Proposed Program Design for Medicaid Managed Care,¹⁵ *North Carolina's Care Management Strategy under Managed Care*,¹⁶ and *Provider Health Plan Quality Performance and Accountability*¹⁷ in August 2017 and March 2018. DHHS also released a Request for Information (RFI) to solicit feedback from potential PHPs and other interested stakeholders on options and considerations related to PHP design and implementation, including several interventions (e.g., value-based payment) addressed by the Quality Strategy.¹⁸ Each of these program design documents laid the groundwork for how DHHS will drive quality, value, care improvement, beneficiary protections, and PHP accountability in a new managed care environment.

Public comments related to Quality focused primarily on quality measures included in this Strategy, as well as the Department's proposed approach to withhold scoring. Of note, the Department has delayed the quality withhold to the third contract year, and will defer finalizing the quality withhold scoring approach in order to learn from first year performance data and stakeholder feedback. In response to comments about measures, DHHS will monitor measure performance and maintain a list of candidate measures that can be added as other measures are phased out due to changes in program requirements (such as requirements for health plan accreditation), topped-out status, or other events. In addition, the launch of tailored plans in the future will present an opportunity to incorporate additional measures of particular relevance to the specific populations covered. Commenters also noted concerns regarding small sample sizes and confidence intervals in measure reporting. DHHS is mindful of these concerns, and in consultation with state statisticians and public health experts, DHHS expects to combine subsamples as appropriate for individual analyses. A number of commenters expressed interest in using a hybrid quality reporting methodology where appropriate; DHHS has determined that it will accept performance results derived from hybrid reporting in those circumstances.

Other Sources of Stakeholder Feedback: As outlined in Section I(B), quality priorities and interventions were derived from review of performance against existing quality measures and outcomes in North Carolina, and built upon the work of the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics. In addition to the stakeholder engagement activities critical to Medicaid transformation, including work on this Quality Strategy, the following steps were taken to receive input on the Quality Strategy itself, consistent with the standards set forth in 42 CFR 438.340(c):

- Input was obtained from the Medical Care Advisory Committee; and
- The Eastern Band of Cherokee Indians (EBCI) Tribe was consulted in accordance with the State's Tribal consultation policy.

DHHS incorporated all comments from all groups as noted, and will make the final Quality Strategy available on its website upon CMS approval.

¹⁵ North Carolina's Proposed Program Design for Medicaid Managed Care. August 2017. Available Online at:

https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf

¹⁶ North Carolina's Care Management Strategy under Managed Care. March 2018. Available Online at:

https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf

¹⁷ Provider Health Plan Quality Performance and Accountability. March 2018. Available Online at:

https://files.nc.gov/ncdhhs/documents/PHP-QualityPerformance-and-Accountability_ConceptPaper_FINAL_20180320.pdf

¹⁸ For additional information on the November 2017 RFIs, see: <https://www.ncdhhs.gov/news/press-releases/dhhs-releases-request-information-medicare-managed-care-program>

Updates to the Quality Strategy

DHHS will review and update the Quality Strategy as needed or upon a significant change, and no less than once every three years.¹⁹ The process for reviewing the Quality Strategy will include an evaluation of its effectiveness in the previous three years (or, if updated sooner, since the Quality Strategy's implementation), the results of which will be made publicly available on the DHHS website. For purposes of updating and reviewing the Quality Strategy, "significant change" is defined as:

- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted by the PHPs that results in a change to the Goals or Objectives of the Quality Strategy;
- Overarching changes to quality standards resulting from regulatory authorities or legislation at the State or federal level; or
- A change in membership demographics or the provider network of 50 percent or greater within one year.

Changes to formatting, dates, or other similar edits are defined as "insignificant," as well as regulatory/legislative changes that do not change the intent or content of the requirements contained within. Changes to the details included in the Appendices of the Quality Strategy will also be considered insignificant, but appendices will be regularly updated as needed in the version of the Quality Strategy posted online.

Updates to the Quality Strategy will be a part of North Carolina's continuous quality improvement process and, as required by 42 CFR 438.340(c)(2)(iii), will consider the recommendations provided by the External Quality Review Organization (EQRO) for: (1) improving the quality of health care services furnished by each PHP; and (2) how DHHS can target Goals and Objectives in the Quality Strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. Additional information regarding the EQRO's quality functions can be found in Section IV(A) and Appendix B of this Quality Strategy.

II. Improvements and Interventions

(A) PHP Quality Assessment and Performance Improvement Programs

DHHS requires that PHPs, in compliance with 42 CFR 438.330 and additional DHHS requirements, establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement program (QAPI) that must be reviewed and approved by DHHS and include:

- Completion of DHHS-specified performance improvement projects (further described under *Performance Improvement Projects* below);
- Collection and submission of all designated quality performance measurement data (outlined in Section I(B));

¹⁹ This Quality Strategy will start at the launch of managed care, currently planned for July 1, 2019, with an update on or before June 30, 2022 or upon significant change.

- Mechanisms to detect both underutilization and overutilization of services;
- Mechanisms to assess the quality and appropriateness of care for beneficiaries with special health care needs (defined in Section III(A));
- Mechanisms to assess and address health disparities, including findings from the EQRO-developed annual health equity report (further discussed in Section IV(A));
- Mechanisms to assess the quality and appropriateness of care provided to beneficiaries needing long-term services and supports, including assessment of care between settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan; and
- Participation in efforts by the State to prevent, detect, and remediate critical incidents.

So that DHHS may monitor and ensure the accuracy of PHP reporting, and assess performance against those measures on a PHP-specific and program-wide basis as described in Section IV(A), PHPs must:

- Provide all quality data outlined in Section I(B) on, at minimum, an annual basis to DHHS and the DHHS-specified EQRO;
- Provide to DHHS all accreditation reports; and
- Provide all information required by the EQRO, in compliance with the protocols set forth by CMS for the EQRO activities outlined in Appendix B.²⁰

In addition to the assessments DHHS and the EQRO will conduct to oversee PHPs' performance against the quality Aims, Objectives, and measures further described in Section I(B), PHPs are also required to develop a process to evaluate the impact and effectiveness of their own QAPIs. A description of this PHP process must be submitted to and approved by DHHS with submission of the QAPI itself and be closely aligned to this Quality Strategy.

Further, PHPs are required to participate in ongoing cross-PHP meetings with DHHS and PHP Quality Directors designed to exchange and build upon PHP-identified best practices, discuss arising issues, and plan for upcoming projects. PHPs are also required to participate in an annual Quality Improvement Collaborative. The Quality Management Committee (further described in Section I(C)) serves as a key DHHS interface with PHPs, and is driven by the data collected throughout the assessment processes further described in Section IV(A).

Performance Improvement Projects (PIPs)

In compliance with 42 CFR 438.330(d), and as part of each QAPI, PHPs are required to conduct PIPs that: are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction; include measurement of performance using objective quality indicators; include implementation of interventions to achieve improvement in the access to and quality of care; include evaluation of the effectiveness of the interventions based on the performance measures included in Appendix A; and include planning and initiation of activities for increasing or sustaining improvement.

²⁰ CMS protocols for EQR-related activities are available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>

Specifically, PHPs are required to conduct at least three (3) PIPs annually, which must be approved by DHHS, and include:²¹

- Two (2) clinical PIPs, for which PHPs may select a topic of choice from the following four topic areas:
 1. Pregnancy intendedness;
 2. Tobacco cessation;
 3. Diabetes; or
 4. Behavioral health integration.
- One (1) non-clinical PIP, which must be aligned to the Aims, Goals, Objectives, and interventions outlined within this Quality Strategy.

In addition to the PIPs required above, for all overall CMS 416 rates²² below 75 percent, each PHP must submit an additional PIP on EPSDT screening and community outreach plans.

PHPs will be required to report the status and results of each PIP conducted no less than once annually; these results will, as noted in this Section and Section IV(A), be validated by the External Quality Review Organization and reviewed by DHHS.

(B) DHHS Quality Management and Improvement Structure

The State's Quality Management approach is designed to measure and monitor PHP performance against PHP requirements through Quality Assurance, Quality Improvement and Innovation activities for all enrollees, including those with Special Health Care Needs.²³ The State plans to utilize its Quality and Population Health Department and both a Quality Management (QM) subcommittee and external advisory Quality Management subcommittee to effectively monitor and review PHP performance across these quality efforts to support key decision-making and ongoing assessment of PHP performance against the Aims, Goals and Objectives previously noted. The external advisory QM Committee will be developed to include PHPs, providers, and other stakeholders, such as beneficiaries. The advisory QM Committee is charged with providing input to DHHS on the following elements of its Quality Strategy and its ongoing execution:

²¹ CMS has not specified standard, nationally required PIPs to date.

²² Form CMS-416 is a required annual Early And Periodic Screening, Diagnostic, and Treatment (EPSDT) screening and participation performance report for state Medicaid agencies to assess the effectiveness of EPSDT services

²³ Adults and children with special health care needs are defined as follows:

Children with Special Health Care Needs are defined as those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.

Adults with Special Health Care Needs are defined as those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to individuals: with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis (including opioid addiction), chronic pain; or receiving 1915(b)(3), Innovations or TBI Waiver services.

- Provide feedback on updates to and revisions of the written Quality Strategy, including accounting for the recommendations put forth by the EQRO
- Provide feedback on the development of and changes to key NC DHHS programs designed to assess PHP performance, reward quality improvement, and ensure PHP accountability, including the PHP withholds program (further discussed in Section IV(A))
- Provide input on updates to the quality measure set PHPs are required to report to DHHS and the measures on the priority measure set, based on statewide priorities, clinical advancements, and/or opportunities to expand the number of CMS Adult and Child Core measures reported

This Committee structure is designed to closely interact with the DHHS management team and staff involved in the development of the interventions described throughout this Quality Strategy and that are contingent upon stakeholder engagement for implementation and ongoing review.

(C) Interventions

North Carolina has developed a series of interventions aligned closely to this Quality Strategy and designed to build an innovative, whole person centered, well-coordinated system of care, that addresses both medical and non-medical drivers of health. These interventions drive progress towards the Quality Strategy Aims, Goals and Objectives described in Section I(B). Further, progress against these Aims, Goals, and Objectives – and the role of interventions in achieving those Goals – will be assessed using the measures defined in Appendix A of this document along with utilization measures defined within and related to individual interventions. Figure 5 provides an overview of these interventions and how they intersect to advance the objectives set forth within this Strategy.

Figure 5. Linking Interventions to Objectives

Intervention	1.1: Timely access to care	1.2: Provider Engagement	2.1: Patient engagement	2.2: Care mgmt. & coordination	2.3: Coordinated physical & BH care	3.1: Child health, development, & wellness	3.2: Women's health	3.3: LTSS quality of life	4.1: Behavioral health care	4.2: Diabetes management	4.3: Asthma management	4.4: Hypertension management	5.1: Unmet resource needs	5.2: Opioid crisis	5.3: Tobacco use	5.4: Reduce health disparities	5.5: Obesity	6.1: High value care
(1) Opioid Strategy		◆			◆				◆				◆	◆				◆
(2) Healthy Opportunities Strategy	◆		◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
(3) Advanced Medical Homes (AMHs)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆

Intervention	1.1: Timely access to care	1.2: Provider Engagement	2.1: Patient engagement	2.2: Care mgmt. & coordination	2.3: Coordinated physical & BH care	3.1: Child health, development, & wellness	3.2: Women's health	3.3: LTSS quality of life	4.1: Behavioral health care	4.2: Diabetes management	4.3: Asthma management	4.4: Hypertension management	5.1: Unmet resource needs	5.2: Opioid crisis	5.3: Tobacco use	5.4: Reduce health disparities	5.5: Obesity	6.1: High value care
(4) Managing High Risk Pregnancies	◆	◆	◆	◆	◆	◆	◆								◆			◆
(5) Care Management for At-Risk Children			◆	◆		◆							◆			◆		◆
(6) Behavioral Health Integration	◆	◆		◆	◆		◆		◆				◆					
(7) Provider Supports		◆		◆	◆								◆					◆
(9) Value-Based Payment (VBP)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
(10) Centers for Disease Control and Prevention (CDC) 6 18 Initiative							◆			◆					◆			◆
(11) Accreditation	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆
(12) Health Equity Reporting & Tracking	◆												◆			◆		

Each intervention is described in brief, below. In addition, many of these interventions are described in further detail in *North Carolina's Proposed Program Design for Medicaid Managed Care*,²⁴ and are described in a series of Concept Papers related to North Carolina's Medicaid Transformation.²⁵

(1) Opioid Strategy

Like many states, North Carolina is facing an opioid crisis that has worsened over the last decade.²⁶ The Quality Strategy, in recognition of this crisis, includes a specific Objective (Objective 5.2) related to addressing

²⁴ North Carolina's Proposed Program Design for Medicaid Managed Care. August 2017. Available Online at: https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf

²⁵ Concept Papers related to North Carolina's Medicaid transformation are available online at: <https://www.ncdhhs.gov/nc-medicare-transformation>

²⁶ North Carolina's Opioid Action Plan, 2017-2020

the opioid crisis, and other Objectives tied to behavioral health, which are impacted by the crisis as well. Building on the NC Opioid Action Plan to reduce opioid addiction and overdose deaths from 2017-2021,²⁷ North Carolina's Medicaid opioid strategy includes reviewing clinical policies related to prevention of opioid misuse and effective chronic pain treatment to ensure alignment with evidence-based best practices and, effective August 2017, requiring prior approval for certain prescriptions or supply sizes. DHHS recently strengthened its beneficiary lock-in program,²⁸ and is working with PHPs to implement multiple strategies, including beneficiary lock-in programs, Strengthen Opioid Misuse Prevention (STOP) Act provisions,²⁹ increasing access to non-opioid and non-pharmacologic pain management modalities, and specialized education, training, and other best practices for chronic pain management and opiate prescribing.

As is further described in Section III(A) of this Strategy, PHPs are required to report on access to Pain Management specialists as part of the State's network adequacy requirements. Finally, DHHS has obtained a waiver of the Institution for Mental Diseases (IMD) exclusion to improve access to residential treatment for substance use disorders, and is considering several other interventions which could further advance efforts in line with this quality Objective. As part of the State's implementation and monitoring plan for this waiver, the State will report multiple substance use and opioid-related measures to CMS and these measures will be incorporated into the Quality Strategy once finalized.

(2) Healthy Opportunities Strategy

Central to the State's effort to improve access, quality, and timeliness of care is a commitment to address the social and environmental factors that directly impact health outcomes and cost, or, the social determinants of health—"the structural determinants and conditions in which people are born, grow, live, work and age."³⁰ Stakeholder feedback has consistently cited food insecurity, housing instability, and transportation challenges as critical barriers to health, among other risks important to underlying health status, such as interpersonal violence and trauma. These and other social determinants disproportionately impact Medicaid beneficiaries, increase the risk of patients developing chronic conditions, and drive cost; further, these social factors are tied to 80 percent of health outcomes.^{31,32}

To effectively address these challenges, the Department is embedding strategies to address social

²⁷ Ibid.

²⁸ The program restricts beneficiaries who meet at least one of the following criteria to a single prescriber and pharmacy: beneficiaries with six claims of opiates, benzodiazepines and certain anxiolytics; beneficiaries receiving prescriptions for these drugs from more than three prescribers in two consecutive months; or referral from a provider, DMA or CCNC. NCHC enrollees are not subject to lock-in provisions

²⁹ NC Session Law 2017-74

³⁰ Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *The Lancet* 372, no. 9650 (Nov. 8, 2008):1661–1669.

³¹ Linkins KW, Brya JJ, Chandler DW. Frequent users of health services initiative: final evaluation report. 2008 Institute of Medicine. 2015. Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: National Academies Press.

³² McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood)* 2002;21:78–93 Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. *Am J Public Health*. 2011;101:1456–65.

determinants into its Medicaid program in several ways, including but not limited to:³³

- A standardized screening instrument related to food insecurity, housing instability, transportation needs, and interpersonal violence, which PHPs will be expected to use to screen Medicaid beneficiaries as they enroll in the plan. PHPs' screening rates constitute a quality measure noted in Sections I(B) and Appendix A³⁴
- Ensuring PHPs provide assistance securing health-related services and resource navigation to beneficiaries identified with unmet health-related resource needs
- Supporting regional public-private pilots to test evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid beneficiaries' housing instability, transportation insecurity, food insecurity and interpersonal violence and toxic stress. PHPs will be required to participate and collaborate with pilot entities and submit quarterly reports on member enrollment, services used and total costs.
- Expanding efforts to map social determinants of health indicators to identify high disparity areas to help guide community planning and resource investment
- Supporting the development of a statewide resource platform accessible both online and through a call center

In subsequent years, additional measures will be developed that assess rates of successful resource linkage and, eventually, improvements tied to addressing unmet resource needs.

(3) Advanced Medical Homes (AMHs)

A key strategy in the transition to managed care is to build on the successes of North Carolina's Primary Care Case Management (PCCM) program through the development of a new Advanced Medical Home (AMH) model. The AMH model is designed to strengthen the ability of primary care practices to offer access to care for managed care beneficiaries (including extended office hours and non-visit based forms of access), enhance comprehensiveness of primary care and care management at the local level, and ensure strong preventive care. AMHs provide comprehensive primary and preventive care services to managed care beneficiaries, including patient-centered access, team-based care, population health management, care coordination across medical and social settings, and care management for high-risk populations.

AMH certification is initially based on the Carolina Access program with placement into three "Tiers" based on practices' ability to take on care management functions at the practice or local level. Over time, standards associated with select Tiers may evolve to encompass other advanced primary care functions,

³³ Certain social determinants of health initiatives are pending waiver authority; for more information, see: <https://www.ncdhhs.gov/news/press-releases/dhhs-submits-amendment-medicaid-waiver-application>

³⁴ Over time, other measures related to this screening may be added – such as the percent of enrollees screened who are high risk and are referred for unmet social needs and/or the percentage of enrollees screened who are high risk and have at least one social determinants of health-related goal in their care plan.

such as integration of behavioral health services. PHPs are required to contract with AMHs, and will be required to make incentive payments linked to quality measures and outcomes that are aligned to this Quality Strategy. PHPs will be limited to a subset of quality measures for their contracting with AMH practices.

For a substantial proportion of the Medicaid managed care population, care management – whether episodic or chronic – will directly involve the AMH care team. The number of beneficiaries assigned to AMH practices is a key PHP performance measure, as is highlighted in Appendix A of this Strategy. The PHP plays a crucial role in monitoring care management activities, and takes direct responsibility for managing the care of any beneficiary not enrolled in an AMH, for whom the AMH is not able to meet his/her needs, or for where a local care manager is not available. PHPs are additionally required to take on care management functions that augment what AMHs can provide directly, and are incented to achieve certain Department-determined thresholds for the provision of care management at the local level.

(4) Managing High-Risk Pregnancies

North Carolina is known for its approach to high-risk pregnancy management, its high participation rate of perinatal providers in the Medicaid program, and its success in reducing maternal and child health disparities. The State cares for high-risk pregnant women through two related initiatives: the Pregnancy Management Program (PMP) and Care Management for High-Risk Pregnancies (CMHRP). The PMP initiative builds on the State's current approach to delivering coordinated maternity care services to pregnant women and seeks to improve maternal health and birth outcomes via alignment of practice requirements, incentives and quality reporting for perinatal providers and across PHPs. At the practice level, the initiative consists of financial incentives tied to use of a standardized screening tool and postpartum follow up,³⁵ standard contracting requirements (e.g., no elective delivery prior to 39 weeks), quality measures, quality improvement activities, and provider engagement activities.³⁶ PHPs are required to follow the parameters of the program when contracting with and reimbursing perinatal providers.

A hallmark of the initiative is the provision of locally-based care management services through CMHRP. Pregnant women at high risk of poor maternal and/or infant outcomes may be referred into the program by maternity or other providers through the use of the standardized screening tool, or identified through PHP claims analysis. While retaining oversight and accountability for outcomes, PHPs are required to contract with Local Health Departments to provide care management services to identified high-risk pregnant women during the first three years of managed care.

PHP performance is linked to the Quality Strategy through the quality measures noted in Section I(B) and Appendix A of this Strategy, which target specific maternal health outcomes.

³⁵ At the start of managed care, PHPs are required to pay practices 50 dollars for every risk screening tool completed at initial visit and 150 dollars for every postpartum visit. Additionally, PHPs must provide an increased rate for vaginal deliveries.

³⁶ For additional information, see: https://files.nc.gov/ncdema/documents/Providers/Programs_Services/care_management/Program-Guide-High-Risk-Pregnancy-and-At-Risk-Children-11072018.pdf

(5) Care Management for At-Risk Children

North Carolina has long been committed to addressing risk factors in children who have been exposed to toxic stress in early childhood, are in foster care, or otherwise have complex social or health needs. The Care Management for At Risk Children (CMARC) program serves children from birth to age five who meet specific risk criteria, providing them with a comprehensive health assessment and dedicated case management services. Consistent with the goals of this Quality Strategy, the program aims to improve health outcomes and reduce costs for enrolled children.

In managed care, PHPs are responsible for care management for high-risk young children and are required to preserve the strengths of the current model, which integrates social supports and provides local care/case management services. While retaining oversight and accountability for outcomes, PHPs are required to contract with Local Health Departments for the provision of CMARC services during the first three years of managed care. As a key component of the broader social determinants of health strategy (described under *Healthy Opportunities Strategy* in this Section of the Quality Strategy), PHPs are expected to screen for, and provide assistance securing health-related services and resource navigation to all beneficiaries, including at-risk children.

PHPs are additionally required to meet quality measures that promote child health, wellness and prevention and are encouraged to develop broader models of care for addressing at-risk children.

(6) Behavioral Health Integration

North Carolina has historically had separate payment and delivery systems for physical health and behavioral health services. At the launch of managed care, Medicaid will, for the first time, receive integrated coverage for behavioral health and physical health services. This integration is a critical component of North Carolina's ability to deliver whole- person, well-coordinated care and is supported by the quality performance measures outlined in Appendix A of this Quality Strategy and tied to Objective 2.2 to address physical and behavioral health comorbidities.

Further, PHPs are required to meet several requirements related to behavioral health needs. PHPs must identify individuals with significant behavioral health needs as a priority population for care management. PHPs are additionally required to comply with network adequacy standards specific to behavioral health providers, a core component of ensuring appropriate access to care, as outlined in Section II(A) of this Quality Strategy.

(7) Provider Supports

Providers are critical partners in ensuring that the Goals and Objectives of the Quality Strategy are achieved and that interventions are successfully deployed. To build upon North Carolina's existing infrastructure to support clinical improvement, the Department is providing, directly and through PHPs, additional resources tailored to advance state interventions and ensure providers' ability to achieve the

goals outlined in this Quality Strategy. The supports are offered to assist providers in engaging in Medicaid transformation, including clinical transformation and care improvement efforts at a practice level.

The Department will be offering state-led training and feedback sessions (e.g. webinars, virtual office hours, in person trainings) to train providers and keep them up to date on programmatic developments. Additionally, PHPs are responsible for training providers on PHP-specific policies and programs, and must develop a Provider Support Plan that will be reviewed by the Department and must be updated on an annual basis.

(9) Value-Based Payment (VBP)

To ensure that payments to providers are increasingly focused on population health outcomes, appropriateness of care, and other measures of value, rather than on a fee-for-service basis, the Department encourages accelerated adoption of Value-Based Payment (VBP) arrangements between PHPs and providers.

PHPs are required and incentivized to develop and lead innovative strategies to increase the use of VBP arrangements over time – including arrangements that appropriately incentivize providers – and are required to submit their VBP strategies to the Department and report on their use of VBP contracting arrangements each year. In addition, by the end of Year 2 of operations, the portion of each PHP’s medical expenditures governed under VBP arrangements must either increase by twenty percentage points, or represent at least fifty percent of total medical expenditures. The Department has defined VBP – for the first two years of PHP operations – as payment arrangements that meet the criteria of the Health Care Payment (HCP) Learning and Action Network (LAN) Advanced Payment Model (APM) Categories 2 through 4.^{37, 38}

In the early years of Medicaid managed care, the Department plans to convene stakeholders to develop a longer- term VBP Roadmap. The stakeholder group will be charged with assessing PHPs’ advancements to date and opportunities to align VBP arrangements across payers and in accordance with statewide priorities. Providers, payers, policy experts and patient advocates will all play an instrumental role in developing an achievable but ambitious VBP Roadmap with specific goals for value-based payment initiatives in future years.

(10) Centers for Disease Control and Prevention (CDC) 6|18 Initiative

In partnership with the CDC, the Department’s Medicaid program is participating with the Division of Public Health in the 6|18 Initiative, which is based on rigorous evidence for six high-burden health conditions and 18 associated interventions designed to have the greatest health and cost impact. As part of this initiative,

³⁷ For more information on the HCP-LAN APM framework, see: <https://hcp-lan.org/groups/apm-fpt-work-products/>

³⁸ North Carolina will require PHPs to conduct an annual assessment using the HCP-LAN assessment form, available online at: <https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf>.

the Department is implementing interventions focused on: (1) reducing tobacco use; (2) preventing unintended pregnancy; and (3) preventing and controlling diabetes. This evidence was used to inform and correlates closely with many elements of this Quality Strategy, including the Objectives focused on these three

specific efforts, and on options PHPs have for completion of required Performance Improvement Projects (described in detail in Section II(A)).

(11) Accreditation

As a key component of ensuring that PHPs are held to consistent, current standards for quality, access, and timeliness of care, PHPs are required to attain accreditation from the National Committee for Quality Assurance (NCQA) by the end of Contract Year 3.

Although PHPs are not required to achieve accreditation until the third year of operations, they must meet key accreditation milestones starting in Contract Year 1, including:

- Meet the clinical practice guidelines required for Health Plan Accreditation set forth by NCQA. 42 C.F.R. 438.236(b).
- Submit all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO for all accredited PHPs.

As noted in Section II(C) of this Quality Strategy, the Department aims to avoid duplication and inconsistency in quality functions completed across the accrediting body, External Quality Review Organization (EQRO), and the Department related to plan operations, quality measurement and assessment, and compliance with Department standards. The Department will streamline these activities over time and, where appropriate, exercise the option to use information provided by the accreditation reports to avoid duplication of mandatory activities as permitted by 42 CFR 438.360.

(12) Health Equity Reporting and Tracking

The measures in Appendix A will serve as the basis for the annual health equity-related analysis. PHPs are directed to report across select measures by select strata, including by age, race, ethnicity, sex, primary language, and disability status, as well as by key population groups (e.g., LTSS) and by geography, where feasible. The Department monitors these reports to identify disparities, and – based on their results over time – will develop (or require PHPs to develop) targeted interventions and/or other strategies to address identified disparities. In particular, the Department plans to set targets for improving health equity; further information about PHPs’ responsibilities related to incorporating equity assessment and performance improvement in their Quality Assessment and Performance Improvement plans is available in Section II(A); the State’s plan to assess for disparities is further discussed in Section IV(A).

(D) Health Information Technology

North Carolina’s Health Information Technology (HIT) system and initiatives support the overall Quality Strategy. The State’s HIT approach is based on a strategy that spans all stakeholders and takes into

consideration current and future plans, policies, processes and technical capabilities. As one of its guiding principles, the Department is responsible for ensuring its information technology vendors are communicating and coordinating with the Department and with one another to create a successful and well- integrated system.

Data will play a crucial role in North Carolina's Medicaid transformation, including its effort to drive a continuous quality improvement process. In support of the overall strategy to improve the quality of care, the Department is leveraging existing technology tools and considering new capabilities that will help clinicians and care managers access a range of information, including patient-level data, alerts on hospital admissions/discharges, patient assessments, risk stratification, care plans, and social determinants. Additionally, the Department is working with stakeholders to establish communication between parties involved in encounter data exchange and to plan for other types of information exchange and required reporting.

III. State Standards for Access, Structure, and Operations

North Carolina's PHP contracts include robust requirements to ensure that PHPs meet, and in many cases, exceed the standards outlined in 42 CFR Part 438, subpart D and as specified by the Department. These standards are detailed throughout this Section of the Quality Strategy and include requirements related to beneficiary access to care such as network adequacy, availability of services, access to care during transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization. Further, these requirements relate to the structure and operations that PHPs must have in place in order to ensure the provision of high quality care including provider selection requirements, practice guidelines, information made available to beneficiaries, enrollment and disenrollment processes, confidentiality, appeals and grievance systems, sub-contractual relationships and delegation, and the information technology utilized by PHPs.

The Department recognizes these PHP requirements as important assurances that member services are adequately and appropriately provided, and further recognizes the importance of monitoring and responding to key indicators of the success of such requirements. As noted throughout this Quality Strategy, and particularly within Section IV(A) and IV(B), the Department uses the following tools to assess beneficiary and provider perceptions of the effectiveness of these efforts:

- The CAHPS Plan Survey (Adult 5.0, Children 4.0, Children Chronic Conditions Supplement and HCBS), which assesses beneficiary perception of care; and
- A standard provider survey tool, which measures provider satisfaction.

(A) State Access Standards

(1) Network Adequacy Standards

PHPs are expected to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the Medicaid and NC Health Choice programs for all beneficiaries, including those with limited English proficiency or physical or mental disabilities, based on

standards developed by the State. To recognize the special needs of accessibility to behavioral health services, the standards include specific measurements for those services. PHPs are expected to also meet standards for appointment wait-times for primary care and specialist care. Per federal regulations at 42 CFR 438.68, PHP networks must meet network adequacy standards that are developed by the State and published online. Network adequacy standards are an important tool for ensuring that beneficiaries have access to providers and care. North Carolina’s network adequacy standards vary by geographic area and include **time and distance standards**, for providers who serve adult and pediatric beneficiary needs, as described in Figures 6 and 7 below, and **appointment wait-time standards**, as described in Figures 8-11.

Figure 6. Network Adequacy Standards: Time and Distance Standards for Adults and Children

Provider Type	Urban Standard ³⁹	Rural Standard ⁴⁰
Primary Care (adult and pediatric)	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
Specialty Care (adult and pediatric) – <i>See below for a list of provider types that are subject to this standard</i>	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members
OB/GYN	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
Hospitals	≥ 1 hospital within 30 minutes or 15 miles for at least 95% of Members	≥ 1 hospital within 30 minutes or 30 miles for at least 95% of Members
Pharmacies	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members
Occupational, Physical, or Speech Therapists	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
Outpatient Behavioral Health Services⁴¹	≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members

³⁹ For the purposes of the state’s network adequacy standards, “urban” is defined as non-rural counties, or counties with average population densities of 250 or more people per square mile. This includes 20 counties that are categorized by the North Carolina Rural Economic Development Center (“the Rural Center”) as “regional cities or suburban counties” or “urban counties.” These 20 counties include 59 percent of the state’s population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

⁴⁰ For the purposes of the network adequacy standards, “rural” is defined as counties with population densities below 250 people per square mile. Per the Rural Center, there are 80 counties in North Carolina that meet this definition; these counties are home to 41 percent of the state’s population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

⁴¹ “Outpatient behavioral health services” includes outpatient behavioral health services provided by direct-enrolled providers (e.g., psychiatry) for adults and children.

Provider Type	Urban Standard ³⁹	Rural Standard ⁴⁰
Location-Based Services (Behavioral Health)⁴²	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
Crisis Services (Behavioral Health)⁴³	≥ 1 provider of each crisis service within each PHP region ⁴⁴	
Inpatient Behavioral Health Services⁴⁵	≥ 1 provider of each inpatient BH service within each PHP region	
Partial Hospitalization (Behavioral Health)	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of Members
Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	≥ 2 providers of clinically managed low-intensity residential treatment services within each PHP region	

North Carolina does not cover any State Plan LTSS services that would require beneficiaries to travel to a provider, and therefore time and distance standards do not apply. The Department requires PHPs to meet the requirements in Figure 7 to ensure access to LTSS services for which providers travel to beneficiaries.

Figure 7. Access Standards for Long Term Services and Supports

Provider Type	Urban Standard	Rural Standard
All State Plan LTSS (except nursing facilities)⁴⁶	PHPs must have at least two LTSS provider types, identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHPs must have at least two providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
Nursing Facilities	PHPs must have at least 1 nursing facility accepting new patients in every county.	PHPs must have at least 1 nursing facility accepting new patients in every county.

⁴² “Location-based behavioral health services” includes: psychosocial rehabilitation (for adults); substance abuse comprehensive outpatient services (for adults); substance abuse intensive outpatient programs (for adults and children); opioid treatments (for adults).

⁴³ A behavioral health crisis is defined as a non-life-threatening situation in which a person experiences an intensive behavioral, emotional, or psychiatric response triggered by a precipitating event. The person may be at risk of harm to self or others, disoriented or out of touch with reality, functionally compromised, or otherwise agitated and unable to be calmed. If this crisis is left untreated, it could result in a behavioral health emergency. For purpose of time and distance standards, “crisis services” does not include mobile crisis services. See the Community/Mobile Services Appointment Wait-time Standards below for a standard for mobile services.

⁴⁴ “PHP region” refers to the six regions identified in the N.C. Legislative Report: “Transformation and Reorganization of North Carolina’s Medicaid and NC Health Choice Programs,” March 1, 2016, <https://files.nc.gov/ncdhhs/Medicaid-NCHC-JLOC-Report-2016-03-01.pdf>. (Note that Alamance County is included in Region IV.)

⁴⁵ For adults, “inpatient behavioral health services” includes: acute care hospitals with adult inpatient psychiatric beds; other hospitals with adult inpatient psychiatric beds; acute care hospitals with adult inpatient substance use beds; and other hospitals with adult inpatient substance use beds. For children, it includes: acute care hospitals with adolescent/child inpatient psychiatric beds; other hospitals with adolescent/child inpatient psychiatric beds; acute care hospitals with adolescent inpatient substance use beds; other hospitals with adolescent inpatient substance use beds.

⁴⁶ “State Plan LTSS” is defined as: Nursing facility, Home Health, personal care, hospice, home infusion therapy, private duty nursing, and durable medical equipment.

Primary Care Access Standards: “Primary care” means basic or general health care provided by a medical professional (such as a general practitioner, pediatrician or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist.

Figure 8. Access Standards for Primary Care

Visit Type	Definition	Standard
Preventive Care Services – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears.	Within 30 calendar days
Preventive Care Services – child, birth through 20 years of age and older		Within 14 calendar days for Members less than 6 months of age Within 30 calendar days for Members 6 months of age and older
Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
Routine/Check-up Appointment without Symptoms	Non-symptomatic visits for health check-up.	Within 30 calendar days
After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately (available 24 hours a day, 365 days a year)

Figure 9. Access Standards for Prenatal Care

Visit Type	Definition	Standard
Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within 14 calendar days
Initial Appointment – high risk pregnancy or 3rd Trimester		Within 5 calendar days

Specialty Care Access Standards: “Specialty care” means specialized health care provided by physicians

whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics and other specialized fields.

Figure 10. Access Standards for Specialty Care

Visit Type	Definition	Standard
Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within 24 hours
Routine/Check-up Appointment without Symptoms	Non-symptomatic visits for health check-up.	Within 30 calendar days
After-Hours Access – Emergent and Urgent Instructions	Care requested after normal business office hours.	Immediately (available 24 hours a day, 365 days a year)

Behavioral Health Care Access Standards: “Behavioral health care” means health care services provided for treatment and services in the community for behavioral and/or substance use disorders. Standard plans cover certain behavioral health care services for individuals with mild to moderate behavioral health care needs. The access standards that follow apply to the services standard plans cover for the mild to moderate population.

Figure 11. Access Standards for Behavioral Health Care

Visit Type	Definition	Standard
Mobile Crisis Management Services	For adults and children, direct and periodic services that are available at all times, 24 hours a day, seven days a week, 365 days a year, and primarily delivered face-to-face with the individual and in locations outside the agency's facility.	Within 30 minutes
Urgent Care Services for Mental Health	<ul style="list-style-type: none"> Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness, or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, will progress to the need for emergency services/care. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention. 	Within 24 hours
Urgent Care Services for SUDs	<ul style="list-style-type: none"> Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care. 	Within 24 hours
Routine Services for Mental Health	<ul style="list-style-type: none"> Services to treat a person who describes signs and symptoms resulting in impaired behavioral, mental, or emotional functioning, which has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life. 	Within 14 calendar days

Visit Type	Definition	Standard
Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual.	Within 14 calendar days
Emergency Services for Mental Health	Services for life-threatening conditions in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations, and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention.	Immediately (available 24 hours a day, 365 days a year)
Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention.	Immediately (available 24 hours a day, 365 days a year)

The adult and pediatric providers that are subject to the State's specialty care standards include:

- Allergy/immunology;
- Anesthesiology;
- Cardiology;
- Dermatology;
- Endocrinology;
- ENT/otolaryngology;

- Gastroenterology;
- General surgery;
- Infectious disease;
- Hematology;
- Nephrology;
- Neurology;
- Oncology;
- Ophthalmology;
- Optometry;
- Orthopedic surgery;
- Pain management (board certified);
- Psychiatry;
- Pulmonology;
- Radiology;
- Rheumatology; and
- Urology.

The State will revisit this list of specialty care providers periodically and revise the list based on the utilization and needs of the PHP enrollee population.

Mandatory Network Providers

In addition to meeting the State’s network adequacy standards, federal and state statute and regulations require PHPs to contract with certain types of providers. Federal regulations require PHP networks to include in their networks at least one federally qualified health center (FQHC), at least one rural health clinic (RHC), and at least one freestanding birth center (FBC), where available, for the PHP’s contracted service area. North Carolina statute⁴⁷ requires PHPs to contract with *all* “essential providers” in their geographical coverage area, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers. Essential providers include: FQHCs; RHCs; rural health centers overseen by DHHS; free/charitable clinics; State veterans homes; and local health departments.

Out of Network Services

In the event the PHP’s provider network is unable to provide necessary covered services to an enrollee, the PHP must adequately and timely cover these services out-of-network for the enrollee for as long as the PHP’s provider network is unable to provide them. PHPs are responsible for communicating administrative requirements (e.g., prior authorization requirements, to the degree prior authorization is not prohibited under federal regulation) and coordinating payment with the out-of-network providers and ensuring the cost to the beneficiary is no greater than it would be if the services were furnished within the network. In certain

⁴⁷ NC Session Law 2015-245 as amended by Session Law 2016-121.

cases where there may be a longer-term need, the PHP and out-of-network provider may be encouraged to engage in single case agreements to ensure both parties understand what is administratively and financially expected and to minimize potential disputes which may disrupt the beneficiary care. Additionally, beneficiaries may switch PHPs under certain conditions during the lock-in period to obtain medically necessary services that are not all available within the PHP's network.

Exceptions to Network Adequacy Standards

PHPs that are unable to meet the network adequacy standards may request an exception for a specific provider type in a specific region. PHPs are required to submit to the State a request for an exception with corresponding information in support of that request. Criteria for State review and acceptance of an exception includes but is not limited to:

- Utilization patterns in the specific service area;
- The number of Medicaid providers in the relevant provider type/specialty practicing in specific service area;
- The history of beneficiary complaints regarding access; and
- Specific geographic considerations;
- The proposed long-term plan by the PHP to address the access to care gap in its network; and The comprehensiveness and appropriateness of the PHP's plan for addressing beneficiary needs, including the PHP's process for making referrals to out-of-network providers, as relevant, and the PHP's use of telemedicine and other telecommunications technology, as appropriate.

Where exception requests are approved, the Department will monitor beneficiary access to the relevant provider types in the relevant regions on an ongoing basis and annually report the findings to CMS, in line with federal regulations.

Telemedicine

PHPs may use telemedicine as a tool for ensuring access to needed services in accordance with the PHP Telemedicine Coverage Policy. When an enrollee requires a medically necessary service that is not available within the State's expected driving distance, the PHP will be expected to ensure that enrollee has access to that service and could utilize either an out-of-network provider or could access the service through telemedicine, if applicable and medically appropriate. The enrollee must have a choice between an out-of-network provider and telemedicine and cannot be forced to receive services through telemedicine. While PHPs may not use telemedicine to meet the State's network adequacy standards, they may leverage telemedicine in their request for an exception from the State's network adequacy standards.

(2) Availability of Services

PHPs must contract with enough providers to ensure that all services covered under the contract are available and accessible to beneficiaries in a timely manner, as required under 42 CFR 438.206. To ensure this, under state law, PHPs must include all willing providers in their networks, except when a PHP is unable to negotiate rates or where there are provider quality concerns. As described previously, PHPs must also contract with all "essential providers" in their area unless the Department approves another arrangement.

North Carolina also seeks to ensure the availability of services through, among other things, its network adequacy standards, which include both time and distance standards and appointment wait-time standards (see above). Other requirements on PHP networks and the availability of services covered under the contract include:

- Direct access to a women’s health specialist for covered care necessary to provide women’s routine and preventive health care services (note that this is in addition to the enrollee’s designated source of primary care if that source is not a women’s health specialist);
- Direct access to emergency services, children’s screening services, primary care services, school-based clinic services and Local Health Department services;
- Direct access to behavioral health services, such that PHPs will not require beneficiaries to obtain a referral or prior authorization for at least one mental health assessment and at least one substance dependence assessment from a participating provider in any calendar year;
- Direct access to covered services offered by family planning providers and/or family planning services;
- Direct access to specialists, for beneficiaries with special health care needs (defined under subsection 3, “Coordination and Continuity of Care”), in a manner that is appropriate for the beneficiaries’ health condition and age;
- Access to a second opinion from either a network provider or an out-of-network provider (to be arranged by the PHP), at no cost to the enrollee;
- Access to necessary covered services from an out-of-network provider for as long as the PHP’s network is unable to provide such services;
- Access to covered services 24 hours a day, 7 days a week, when medically necessary;
- Access to network providers during hours of operation that are no less than the hours of operation offered to commercial enrollees or, if the provider serves only Medicaid beneficiaries, comparable to Medicaid FFS;
- Timely access to contracted services for the tribal population;
- Access to pharmacy network within time and distance standards;
- Access to telemedicine as a tool for facilitating timely access to needed services that are not available within the PHP’s network and in accordance with the PHP Telemedicine Coverage Policy.

PHPs must also ensure the availability and delivery of services in a culturally and linguistically competent manner to all beneficiaries, including those with limited English proficiency and literacy and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. PHPs must also ensure that network providers deliver physical access, reasonable accommodations, and accessible equipment for beneficiaries with physical or mental disabilities.

(3) Access to Care During Transitions of Coverage

In compliance with the transition of care policy requirements set forth by 42 CFR 438.62, North Carolina has established transition of care standards that apply to all beneficiaries, including those in need of long-term services and supports (LTSS).

In instances in which a beneficiary transitions into a PHP (either from FFS or another PHP or coverage type):

- When a beneficiary is in ongoing course of treatment or has an ongoing special condition where switching providers may disrupt the enrollee's care, the beneficiary may continue seeing his/her provider (even if they are out-of-network) for up to 90 days.⁴⁸
- New enrollees who are pregnant and in their 2nd or 3rd trimester may continue seeing their provider(s) through their pregnancy and up to 60 days after delivery.

When a provider in good standing⁴⁹ leaves a PHP's network:

- PHP enrollees may continue seeing that provider for up to 90 days.
- PHP enrollees who are pregnant and in their 2nd or 3rd trimester may continue seeing the provider through pregnancy and up to 60 days after delivery.

(4) Assurances of Adequate Capacity and Services

In accordance with 42 CFR 438.207, North Carolina maintains a monitoring and oversight system to ensure that PHPs have adequate capacity to provide care to all beneficiaries in their respective service areas. Key components of the State's monitoring and oversight activities include, but are not limited to:

- Requiring PHPs to submit an access plan and regular documentation (including provider network data and report(s) that summarize findings from PHPs' own network data analysis) to demonstrate network adequacy;
- Requiring PHPs to submit updated machine-readable provider directories in a standardized format;
- Contracting with an external quality review organization (EQRO) to review *and* validate PHP data and findings;
- Requiring that PHPs be accredited (by year 3);
- Monitoring beneficiary complaints related to access to care and provider networks;
- Reviewing quality measurement data to show realized access;
- Reviewing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey findings related to beneficiary experience of availability and access to services and taking action as needed; and
- When necessary, issuing Corrective Action Plans (CAPs) when PHPs are identified as non-compliant with network adequacy standards and access requirements.

As outlined in Appendix B, the Department will contract with a qualified EQRO to perform an annual external quality review (EQR) of each PHP to, among other things, determine PHP compliance with network adequacy and access requirements, confirm the adequacy of each PHP's network, and validate PHPs' data. The EQRO must include the findings of the annual EQR in a technical report, which will be posted on the

⁴⁸ At the time standard plans are launched, an enrollee who is in an ongoing course of treatment for a benefit only offered through LME-MCOs will be required to remain in fee-for-service/LME-MCO coverage to continue receiving that benefit.

⁴⁹ Good standing" means the provider is not terminated due to quality or other reasons, such as fraud, from the PHP's network

State's website. The Department will monitor beneficiary access to care issues, including using geographic mapping and other techniques.

(5) Coordination and Continuity of Care

Care and Coordination of Services

PHPs have overall responsibility for ensuring that all beneficiaries have an ongoing source of care according to their needs, and communicate this responsibility along with a point of contact at the PHP, as required by 42 CFR 438.208(b). PHPs are responsible for coordinating services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. In the event that a beneficiary changes enrollment across PHPs or the fee for service program (for example, once a beneficiary exceeds 90-days in a nursing home), PHPs are required to coordinate with other source(s) of coverage to ensure continuity and non-duplication of services.

PHPs are additionally responsible for assessing risk in their enrolled populations, including risk based on social determinants of health, rising risk, and other risks. As required by 42 CFR 438.208(b)(3), PHPs are required to make best efforts to conduct a universal screening process for newly enrolled beneficiaries within 90 days of enrollment. The Department requires PHPs to include within their initial screening tools standardized questions relating to highest-priority social determinants of health (housing, food, transportation, and interpersonal violence). PHPs are required to implement a care management strategy that takes the results of these screenings into account as well as markers of high cost based on past claims (including pharmacy). In recognition that care management for those with complex health and/or social needs is most effective when delivered in the community, PHPs are required to meet State requirements to ensure that care management for high-needs beneficiaries is delivered in predominantly community settings at a local level. As required by 42 CFR 438.208(b)(iv), PHPs are required to coordinate their services with those received from community and social support providers.

Primary care practices, including those that operate as AMHs, play a critical role in care management and care coordination for PHP enrollees. Particularly for those with chronic health needs, care management is most effective when delivered locally. PHPs are required to deliver care management locally to the maximum extent possible (including by AMHs and other local care managers, such as Local Health Departments), while also taking into account the diversity of North Carolina's delivery system.

Additional Services for Beneficiaries with Special Health Care Needs or Who Need LTSS

For beneficiaries who have special health care needs and beneficiaries who need LTSS, PHPs are required, in compliance with the parameters set forth in 42 CFR 438.208(c), to conduct a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Adults and children with special health care needs are defined as follows:

- **Children with Special Health Care Needs** are defined as those who have or are at increased risk of

having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.

- **Adults with Special Health Care Needs** are defined as those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to individuals: with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis (including opioid addiction), chronic pain; or receiving 1915(b)(3), Innovations or TBI Waiver services.

Based on the comprehensive assessment, the State requires PHPs to identify enrollees who require LTSS and to develop a person-centered care plan for such enrollees. The care plan must be developed by a person with expertise in LTSS service coordination and trained in person-centered planning processes. The PHP also must ensure that a beneficiary with special health care needs determined through assessment to require a course of treatment or regular care monitoring has direct access to a specialist as appropriate for the enrollee's condition and identified needs.

PHPs are responsible for identifying individuals with special health care needs and in need of LTSS primarily through the use of a claims data review, predictive modeling, and/or care needs screening. PHPs are required to use this information to ensure the development of an appropriate treatment/service plan as described above.

(6) Coverage and Authorization of Services

PHPs are required to cover the same services as are required in Medicaid fee-for-service, except for a small number of services carved out of Medicaid managed care by statute.⁵⁰ Consistent with the requirements set forth in 42 CFR 438.210, North Carolina has developed an approach to PHP clinical coverage policies and utilization management (UM) that safeguards beneficiary access to services while encouraging PHP innovation.

PHPs are required to use the North Carolina definition of medical necessity, defined in 10A NCAC 25A.0201, when making coverage determinations and are prohibited from setting benefit limits that are more stringent

⁵⁰ NC Session Law 2015-245, as amended, excludes dental services; services provided through the Program of All-Inclusive Care for the Elderly; (PACE); services documented in an Individualized Education Program (IEP) and provided or billed by Local Education Agencies; services provided and billed by a Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan; services for Medicaid program applicants during the period of time prior to eligibility determination.; and the fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames. The Department also recommends that the fitting and the provider visual aid dispensing fee for eyeglasses be carved out of managed care, which would require a statutory change. Currently, S.L. 2015-245 also carves out Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) for four years after the date capitated contracts begin. The Department is seeking a statutory change.

than in the State's fee-for-service program. For example, if the fee-for-service program covered 10 visits for a specific service, PHPs could cover 12 visits, but could not limit a beneficiary to a visit amount less than 10.

The Department requires that PHPs use a common prior authorization request form for all services. PHPs are additionally required to use a standard request process for "in-lieu of services," designed to encourage PHPs to cover services or settings that are not otherwise covered under the State Plan but are a medically appropriate, cost-effective alternative to a service that is covered.

Finally, for a limited number of services, the Department requires that PHPs follow specific clinical coverage policies developed by the State.

(B) Structure and Operations Standards

(1) Provider Selection

PHPs are required to implement written policies and procedures for the selection and retention of network providers. These policies and procedures must meet State and federal requirements, including:

- **"Any willing provider" requirement:** PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates.⁵¹
- **Credentialing and re-credentialing:** PHPs must follow a documented process that is in line with the State's uniform credentialing policy and centralized credentialing verification program for making a quality determination to move to contracting or re-contracting with network providers.
- **Enrolled providers:** PHPs may only contract with providers who are enrolled in the Fee-for-Service program.
- **Nondiscrimination:** In selecting and contracting with network providers, PHPs must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- **Excluded providers:** PHPs may not employ or contract with providers that are excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

(2) Practice Guidelines

Consistent with the requirements of 42 CFR 438.236, PHPs are required to develop practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
- Consider the needs of beneficiaries;

⁵¹ NC Session Law 2015-245 as amended by Session Law 2016-121. Note that this state statute also requires PHPs to contract with all providers in their geographical coverage area that are designated by the Department as "essential providers" (see the "Mandatory Network Providers" section above), unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

- Are adopted in consultation with contracting health care professionals;
- Are reviewed and updated periodically as appropriate; and
- Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation set forth by the National Committee for Quality Assurance (NCQA). 42 CFR 438.236(b).

Additionally, the Department requires that PHPs meet the following standards:

- The PHP's QI Committee or other designated committee must approve clinical practice guidelines;
- The PHP must adopt guidelines from recognized sources or feedback of board-certified practitioners from appropriate specialties that would use the guidance;
- The PHP must adopt guidelines for at least two medical conditions and at least two behavioral health conditions, with at least one behavioral health guideline that addresses children and adolescents;
- The PHP must update guidelines against clinical evidence at least every two years, or more frequently if the national guidelines change within the two-year period;
- The PHP must annually evaluate the consistency with which health care professionals in UM apply criteria in decision making;
- The PHP must act on opportunities to improve consistency, if applicable;
- The PHP must distribute clinical practice guidelines and revisions to all practitioners who are likely to use them; and
- As requested by the Department, PHPs must submit to the Department a copy of any required clinical practice guidelines and make the PHP's Chief Medical Office (or designee) available to discuss the coordination of clinical practice guidelines and clinical coverage policies.

PHPs are required to disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. PHPs will make decisions related to utilization management, beneficiary education, and coverage of services consistent with these guidelines.

(3) Enrollee Information

To ensure the capacity for Medicaid managed care education and PHP/ Primary Care Provider (PCP) selection support at Medicaid managed care launch, the Department will procure an enrollment broker to facilitate outreach, education, and consumer assistance to enrollees and potential enrollees.

Furthermore, in accordance with State standards and the federal requirements in 42 CFR 438.10, all informational materials developed by the State, the enrollment broker, the ombudsman program and PHPs will be made available in formats and languages that ensure their accessibility, including that materials are provided at an appropriate reading level.

Recognizing the importance of beneficiaries receiving consistent and accurate information about how to effectively use the managed care program, the State will develop a model member handbook that all PHPs must customize and use. The member handbook will include the following information:

- Benefits provided by the PHP, including the amount, duration and scope of those benefits, and guidance on how and where to access benefits, including carved out services, non-emergency transportation, EPSDT, family planning services and supplies from out-of-network providers;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the beneficiary's AMH/PCP;
- Overview of the continuation of benefits policy, including when, why, and how a member or member's authorized representative may file for a continuation of benefits;
- The extent to which, and how, after-hours and emergency coverage are provided;
- Any restrictions on the beneficiary's freedom of choice among in-network and out-of-network providers;
- Cost sharing imposed on North Carolina Medicaid or NC Health Choice beneficiaries;
- Beneficiary rights and responsibilities;
- Member enrollment and disenrollment policy and the process of selecting and changing the beneficiary's AMH/PCP;
- Grievance, appeal, and State Fair Hearing procedures and timeframes;
- How to exercise an advance directive, as set forth in federal requirements;
- The toll-free telephone number for the Member Services Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line and how to access auxiliary aids and services, including additional information in alternative formats or languages; and
- Information on how to report suspected fraud, waste or abuse;
- Information on the Opioid Misuse Prevention Program, PHP's prevention and population health programs, and PHP Transition of Care Policy.

PHPs are permitted to provide this information by mail or email (only if beneficiary has expressed consent for email), in addition to posting online.

Information provided will promote the delivery of service in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

Provider Directories

PHPs must compile in a format specified by the Department and make available to enrollees and potential enrollees the following information about all its network providers. This information, comprising the PHP provider directory, must be made available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance with 42 CFR 438.10, the Contract, and as specified by Department.⁵²

- Provider names (first, middle, last)

⁵² Per federal regulations, PHPs must make their provider directories available in the prevalent non-English languages in their particular service areas and in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost.

- Group affiliation(s) (i.e., organization or facility name(s), if applicable)
- Street address(es) of service location(s)
- County(ies) of service location(s)
- Telephone number(s) at each location
- Website URL(s)
- Provider specialty
- Whether provider is accepting new beneficiaries
- Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office
- Whether provider has completed cultural competency training
- Office accessibility (i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment)
- Telephone number that beneficiaries can call to confirm the information in the directory

Per 42 CFR 438.10, information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 10 business days after the PHP receives updated provider information. Provider directories must be posted on the PHP's website, in a machine-readable file and format, as specified by the State.

(4) Enrollment and Disenrollment

In designing the managed care enrollment and disenrollment policies, North Carolina recognizes the importance of ensuring Medicaid and NC Health Choice applicants and their families experience a simple, streamlined eligibility and enrollment process that ensures a timely and accurate determination of Medicaid eligibility and user-friendly PHP, AMH, and PCP selection process. In the future, the Department envisions beneficiaries applying for health coverage, receiving an eligibility determination, and selecting a PHP based on their preferred PCP with the help of educational resources in one sitting. The State and the enrollment broker will be responsible for effectuating enrollment and disenrollment requirements consistent with those set forth in 42 CFR 438.54 and 438.56.

Enrollment

The Department has sole authority to direct enrollment and disenrollment of beneficiaries into and out of Medicaid Managed Care. In partnership with an Enrollment Broker, the Department will educate beneficiaries on Medicaid Managed Care, support their selection of a PHP, and transmit enrollment selections and approved disenrollment requests to the PHP to effectuate.

As part of the transition to Medicaid managed care and prior to the launch in November 2019, the Department will establish a 60-day open enrollment period for current Medicaid beneficiaries to select a PHP. During the open enrollment period, the Enrollment Broker will engage in proactive outreach that explains the Enrollment Broker's services, provides managed care education, and supports PHP and AMH/PCP selection to beneficiaries eligible for Medicaid Managed Care.

Upon Medicaid managed care launch, new Medicaid applicants will be given an opportunity to select a PHP and AMH/PCP as part of the eligibility application process. Individuals who do not select a PHP at application will be auto-assigned by the Department into a PHP based on an algorithm that takes into account available information including whether they are a member of a special population (e.g., member of a federally recognized tribe or in foster care), his or her geographic location, provider-beneficiary relationship, PHP assignments for other family members and equitable PHP distribution with enrollment ceilings and floors for each PHP to be used as guidelines. The beneficiary will be sent a notice informing them of the PHP auto-assignment and given 90 days to change their PHPs for any reason.

North Carolina has a long history of serving beneficiaries through the medical home model and recognizes how important it is to preserve beneficiary-provider relationships in the transition to managed care. The Department is committed to creating a one-stop-shop experience that allows beneficiaries to select a PHP and AMH/PCP during the application process, whether the individual applies online, over the phone, through the mail or in-person. Applicants will be encouraged and given tools (such as a provider search tool) to help them base their PHP selection on their provider relationships and select their AMH/PCP at the time they select their PHP. Applicants who do not select a PCP will be auto-assigned to one by their PHP.

Certain special populations have enrollment processes tailored to their unique needs or circumstances. For example, because all members of a federally recognized tribe are exempt from managed care, the State will ensure that tribal members are educated about their option to either enroll in fee-for-service or in managed care and the implications of their selection.

Switching Plans/Disenrollment

All managed care beneficiaries – whether they select or are assigned to a PHP – have a 90-day period following the PHP effective coverage date or date of notice of new PHP enrollment (referred to as the choice period) to switch PHPs “without cause.” After the completion of the 90-day period, most beneficiaries must remain enrolled in their PHP for the remainder of their eligibility period unless they can demonstrate a “with cause” reason for switching.⁵³ Certain special populations may switch PHPs “without cause” at any time, including members of a federally recognized tribe and beneficiaries receiving LTSS in institutional or community-based settings. All beneficiaries will have the option to switch plans annually at the time of eligibility redetermination.

In rare cases, PHPs will be permitted to request to the Department beneficiary disenrollment only if the enrollee’s behavior seriously hinders the PHP’s ability to care for the beneficiary or other members and the PHP has documented efforts to resolve the enrollee’s issues that form the basis of the request for disenrollment of the member. Consistent with 42 CFR 438.56, PHPs will be prohibited from requesting

⁵³ In addition to the reasons specified in 42 CFR 438.56(d)(2)(i-iv), the State considers the following as cause for disenrollment: the enrollee’s complex medical conditions would be better served under a different PHP; a family member becomes newly eligible and is enrolled in a different PHP; poor performance of PHP, upon launch of evaluations of PHP performance; a PHP was sanctioned which resulted in a suspension of all new enrollment.

beneficiary disenrollment because of an adverse change in the enrollee's health status, enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs.

(5) Confidentiality

To ensure compliance with 42 CFR 438.224, PHP contracts will require that the PHP ensure that it, its network providers and subcontractors comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, "HIPAA") and The Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH") and all applicable federal and state privacy laws that are more restrictive. Accordingly, beneficiaries must be notified of any inappropriate disclosures as required by law.

(6) Grievance and Appeals Systems

The Department is committed to ensuring that beneficiaries are able to address their problems quickly and with minimal burden, and requires PHPs to meet the standards set forth in 42 CFR 438.228. North Carolina is committed to honoring and supporting the right of beneficiaries to pursue a formal appeal of an adverse benefit determination through their PHP, or upon exhaustion of the PHP appeal process, through timely access to a State fair hearing. (42 CFR §§ 438. 228, 438.400, 438.402) Additionally, beneficiaries will also be able to appeal enrollment and disenrollment determinations by the enrollment broker under a similar process.

Beneficiaries also will be provided the opportunity to file a grievance with their PHP to express their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or PHP employee). The Department will require PHPs to report on their appeal and grievance processes and outcomes, and monitor PHP performance to ensure compliance with related requirements and address any issues that may arise.

Beneficiary Grievances

Beneficiaries may file a grievance with a PHP at any time, either orally or in writing. PHPs are required to acknowledge receipt of each grievance in writing within five calendar days and must resolve the grievance within 30 calendar days from the date the PHP receives the grievance. In instances in which the grievance relates to the denial of an expedited appeal request, PHPs are required to resolve the grievance and provide notice to all affected parties within five calendar days from the date the PHP receives the grievance, and include within the notice Department-specified content. These standards comply with Federal requirements for beneficiary grievances. (42 CFR §§ 438.402 and 438.406)

Beneficiary Appeals

Federal law sets forth the specific standards for beneficiary rights for appeals which all PHPs are expected to follow. (42 CFR §§ 438.402; 438.406; 438.408; and 438.420.) Specifically, in North Carolina beneficiaries in Medicaid managed care must first seek to resolve appeals with their PHP and will have 60 days from the

date of the notice of an adverse benefit determination to file a request for an appeal with the PHP. PHPs are required to send written acknowledgement of the request within five calendar days for a standard appeal and within 24 hours for an expedited appeal request. To ensure access to services, beneficiaries may request that their benefits be continued or reinstated while the appeal is pending.

PHPs must provide written notice of resolution as expeditiously as the appellant's health condition requires and within 30 calendar days of receipt of a standard appeal request. For an expedited appeal request, PHPs must provide written notice of resolution, and make "reasonable effort" to provide oral notice within 72 hours of receipt of an appeal.

If the PHP upholds the adverse benefit determination, the beneficiary may request a State fair hearing through the Office of Administrative Hearings; the request must be made no later than 120 calendar days from the date of the notice. Beneficiaries will have the right to request a continuation of benefits while the appeal is pending.

Ombudsman Program

North Carolina is committed to providing beneficiaries with support and active preparation related to the appeals, grievance and State fair hearing process, as well as to facilitating real-time issue resolution. The Department will seek funding to support the establishment of an ombudsman program external to the Department focused on providing advocacy, assistance and education to beneficiaries while navigating the Medicaid managed care system and the appeals, grievance and fair hearing process.

The ombudsman program also will serve an oversight function, monitoring trends in PHP performance or beneficiary concerns, and proactively providing feedback to the Department regarding any issues that arise.

In order to ensure PHP compliance with the appeals and grievances requirements set forth by the Department, PHPs are required to report:

- Each notice of adverse benefit determination, including Department-specified data points related to the determination;
- Department-specified information related to the outcome of the appeal;
- The number of expedited appeal requests and number of expedited appeal denial requests;
- The number and reason for any extensions of appeal resolution timeframes;
- The number of administrative denials of benefits and "inability to process" denials;
- Department-specified data elements related to the reasoning for grievances, timing of receipt and review / review meetings, and the date of grievance resolution.

(7) Sub-Contractual Relationships and Delegation

All PHP sub-contractual relationships and delegations of services or functions on behalf of the PHP under the PHP contracts are required to comply with 42 CFR 438.230. PHPs will remain accountable for all contract terms which are performed by subcontractors and delegation. PHPs will be required to complete pre-delegation assessments or reviews prior to the effective delegation date to assess readiness. As part of the

readiness review, DHHS confirms that PHPs have the necessary policies, procedures, and documents to evidence such compliance and periodically audit PHPs' compliance with this requirement during the term of the contract.

(8) PHP Health Information Technology

As required under 42 CFR 438.242, North Carolina requires each PHP to maintain health information systems that collect, analyze, integrate, and report encounter data and other types of information to support utilization, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility. PHPs will also be expected to support effective and efficient care management and coordination through their health information technology systems working in concert with Medicaid providers and other entities. State law mandates that by June 1, 2018, most Medicaid providers, including hospitals, physicians, physician assistants, and nurse practitioners who provide Medicaid services and who have an electronic health record system must be connected to the designated statewide health information exchange, HealthConnex. All other Medicaid providers must connect by June 1, 2019.

IV. Assessment

There are several mechanisms the Department uses to monitor and enforce PHP compliance with the standards set forth throughout this Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care beneficiaries. The following sections provide an overview of the key mechanisms utilized by the Department to enforce these standards and identify ongoing opportunities for improvement.

(A) Assessment of Quality and Appropriateness of Care

Section II(A) describes the quality assessment and performance improvement programs (QAPIs) PHPs are required to implement to comply with federal and Department standards. The Department uses those PHP required reports and data elements, as well as those developed by the Department and the EQRO, to assess and, when needed, correct the quality of care provided by PHPs. Further, this information is used to drive continuous quality improvement activities including those related to monitoring performance against and updating this Quality Strategy.

To monitor and ensure the accuracy of PHP reporting and performance against quality measures on a PHP-specific and program-wide basis, the Department:

- [Reviews PHP's interim and annual performance against measure benchmarks](#)
- Requires, reviews and approves each PHP's QAPI, including how the PHP will assess and improve upon its own performance against its QAPI on an annual basis;
- Sets parameters for the performance improvement projects (PIPs) described in Section II(B), including changes to such programs based on Department-identified quality priorities and opportunities for targeted improvement;
- Conducts monthly and as otherwise needed PHP Quality Director meetings, to engage with PHPs and address issues as they arise;

- Reviews all accreditation and EQRO compliance reports to determine areas of deficiency including and, as needed, sets forth and monitors PHP corrective actions plans;
- Works closely with EQRO to develop the requirements for and understand opportunities for improvement as a result of the health equity report discussed within this section of the Strategy;
- Publishes the quality data described in Section I(A), in order to promote transparency regarding PHP and program performance and engage stakeholders on opportunities for improvement;
- Designs and administers the quality withhold program, further discussed below; and
- Utilizes the EQRO quality performance reports, outlined in Figure 10 below to drive improvement and performance against the Quality Strategy.

Further, upon PHPs' completion of accreditation requirements (as discussed in Section II(C)(8)), the Department will determine which activities, if any, will be deemed met by accreditation. To ensure that information can be accurately and readily compared across PHPs and within the program broadly, EQRO activities will not be deemed met by accreditation until all PHPs are required to have met consistent accreditation standards. Any requirements deemed by completion of accreditation requirements will be implemented in compliance with the standards set forth in 42 CFR 438.360 related to the non-duplication of mandatory activities with accreditation review.

Figure 12. EQRO Functions Related to Quality Assessment and Performance Improvement⁵⁴

EQRO Activities
<ul style="list-style-type: none"> • Validate PHPs' performance improvement projects outlined in Section II(A) of this Quality Strategy • Validate all PHP-submitted quality performance measures outlined in Section I(B), and aggregate measures for collective review by the Department • Calculate performance measures in addition to those reported by PHPs and validated by the EQRO, as requested by the Department • Conduct the CAHPS Plan Survey • Validate the encounter data reported by PHPs • Produce an annual technical report that summarizes findings on access and quality of care, including: <ol style="list-style-type: none"> 1. A description of the manner in which the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality of care provided by each PHP; 2. An assessment of each PHP's strengths and weaknesses for the quality of care provided; 3. Recommendations for improving the quality of health care services provided by each PHP; 4. Comparative information about all PHPs; and 5. Starting in year 2 of PHP operations, an assessment of the degree to which each PHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's external quality review. • Produce an annual health equity analysis, assessing PHP and program-wide performance against select measures indicated in Appendix A based on select strata including age, race, ethnicity, sex, primary language, disability status, and a breakdown of measures for key population groups (e.g., LTSS, based on aged/blind/disabled status).

⁵⁴ Figure 10 contains only those EQRO activities related to the quality improvement activities described within this section of the Quality Strategy. For a full list of the activities conducted by the EQRO and discussed throughout this document, see Appendix E.

EQRO Activities

- Provide technical assistance, as directed by DHHS, to PHPs as related to conducting PIPs, quality reporting, and accreditation preparedness.

Improving Equity in Care and Outcomes

In compliance with the requirements set forth in 42 CFR 438.340 (b)(6) and as discussed in Section I(B), PHPs must report select measures outlined in Appendix A based on select strata including age, race, ethnicity, sex, primary language, and disability status, *where feasible*.^{55 56} This information is provided to PHPs upon beneficiary enrollment, and is used by the Department to better understand disparities of care within and across PHPs, and by the EQRO to develop an annual health equity report that identifies trends in variation in health services and outcomes based on the factors noted above, in addition to geography. This analysis is intended to support the State's development of a plan of action for measuring and evaluating efforts to remediate disparities in the Medicaid program. The Department will take into consideration the results of this analysis, and develop focused interventions where practicable. As appropriate, these interventions will include:

- Development of disparity-specific quality measure improvement targets, on a program-wide and/or PHP-specific basis;
- Adjustment to, or the introduction of new, program-wide interventions and/or policies catered to the needs of those identified populations;
- Development of modified, or additional, PHP performance improvement project (PIP) requirements; and/or
- Additional requirements for PHP quality assessment and performance improvement programs (QAPIs), further described in Section II(A) of this Quality Strategy.

the Department will use the health equity analysis, along with other reports such as those from accrediting bodies and generated within the Department, in its annual review of each PHP's proposed QAPI to ensure that each PHP is actively assessing – and responding to – opportunities to improve health disparities in collaboration with Department-developed, cross-PHP interventions. The Department is committed to developing measure targets that not only address overall continuous quality improvement, but target opportunities to improve health disparities.

PHP Withhold Program

PHPs are required to meet several performance and reporting thresholds (which may be met through hybrid reporting where appropriate) to remain in compliance with the Department contract provisions; failure to achieve these minimum performance thresholds may result in sanctions (as further described in Section IV(C)). Additionally, there are a number of priority areas where the Department will encourage PHPs to perform beyond compliance thresholds through a uniquely designed withhold program, in which a portion of each PHP's capitation rate is withheld and paid when the PHP meets reasonably achievable performance

⁵⁵ Consistent with the requirements set forth in 42 CFR 438.340(b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability.

⁵⁶ This demographic information is collected via the Medicaid application and transmitted to PHPs at the time of enrollment.

targets. The Department is planning to launch a withhold program in Contract Year 3 (starting July 1, 2021).

In accordance with the requirements set forth in 42 CFR 438.6 and the Department's goal to advance the withhold program to focus on key performance improvement areas over time, the withhold payment opportunities outlined in Figure 13 below will likely be included during the first year of the PHP withhold program. The Department will update the expected withhold elements during scheduled updates of the Quality Strategy, or with ad hoc updates as needed.

Figure 13. Expected PHP Withhold Program Initial Measurement Areas

Expected Withhold Measurement Area	Overview
Quality Measure Performance	PHP performance aligned to set targets on a subset of required measures in Appendix A
Provision of "Local" Care Management	Thresholds related to PHPs contracting with Tier 3 AMH practices that are equipped to provide care management locally
Social Determinants of Health	Performance standards related to addressing beneficiaries' unmet social needs, such as completing care needs screenings and referring identified beneficiaries with unmet resource needs to social services

(B) Monitoring and Compliance of PHP Access, Structure, and Operations

PHPs are contractually required to collect and submit timely encounter, quality, and performance data to the Department. PHPs are also required to submit reports on a range of other metrics, as discussed throughout this Quality Strategy, including demonstration of network adequacy, value-based contracting arrangements and volume, nature, and outcomes of grievances and appeals. These reports are essential to the Department's ability to evaluate the program and hold PHPs accountable. In addition to the Department's monitoring, the North Carolina Department of Insurance (DOI) licenses PHPs and ensures that they meet solvency standards through processes similar to those used for existing commercial managed care plans.

The Department requires approval of and performs monitoring against PHPs' compliance with access, structure and operations through a variety of concurrent mechanisms, including those housed within the State and those conducted through external quality review (as outlined in Appendix B). The Department ensures PHPs' compliance with the standards set forth in this Quality Strategy and required by PHP contracts by:

- Reviewing PHP's governing policies and procedures during readiness and EQR reviews, and as necessary to ensure compliance with the PHP contract.
- Requiring the reports set forth throughout this Strategy and within PHP contracts. The Department reviews each report to ensure continued compliance with the relevant contractual requirement and tracks and trends any potential non-compliance to engage the PHP in corrective action prior to the PHP being noncompliant. For example, and as is discussed in Section III(B)(6), the Department

requires PHPs to submit monthly report on beneficiary grievances and appeals to ensure timeliness of those required processes.

- Auditing PHPs at any time, for any reason, if there is a suspicion of non-compliance or deficiency. In such instances, the Department may require the PHP to submit a Corrective Action Plan (CAP) or take other corrective action, including imposing liquidated damages and/or intermediate sanctions.
- Reviewing, as determined by the Department, PHPs' Compliance Plans, and any other policy and procedure governing how PHPs monitor compliance and quality of services provided by their networks, at any time.⁵⁷
- Annually review the PHPs' required Fraud Prevention Plan and require the PHP to make any modifications, and the State may also require a PHP to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the PHP's Fraud Prevention Plan. PHPs will also submit an annual Fraud Prevention Report outlining the outcome and scope of the activities set forth in its Fraud Prevention Plan, including, at a minimum, the items listed in Appendix C.

Based on the EQRO's review of PHPs' compliance with contractual requirements and/or any deficiencies identified with requirements that results in a Notice of Deficiency (NOD) issued by the Department to the PHP, the PHP, at a minimum, is required to submit a Corrective Action Plan (CAP). The CAP must address each deficiency specifically and provide a timeline by which corrective action will be completed. Follow-up reviews may be conducted as appropriate to assess the PHP's progress in implementing and/or validation of its implementation of the CAP. This issuance of an NOD will not preclude the State from imposing intermediate sanctions, for instance, in the event that potential member harm, or fraud or abuse, or substantial non-compliance with contractual requirements is identified.

Provider Screening

The Department also serves as the gatekeeper to the Medicaid program by screening providers for enrollment in the Medicaid program. This is based on each provider's assignment into risk categories, collecting and evaluating the provider's ownership and control disclosure forms, and performing monthly screenings of all Medicaid enrolled providers against:

- The Social Security Administration's Death Master File;
- The National Plan and Provider Enumeration System (NPPES);
- The List of Excluded Individuals/Entities (LEIE);
- The System for Award Management (SAM); and
- The Department's Excluded Provider List (collectively, the "Exclusion Lists").

Additionally, all providers are subject to criminal background checks by the Department. Providers must be enrolled in North Carolina Medicaid and have gone through North Carolina's centralized credentialing

⁵⁷ PHPs are required to have in effect a Compliance Plan which complies with 42 CFR 438.608.

program to participate in the PHP program.

PHPs are also required to perform precontracting and monthly screenings of all network providers against the Exclusion Lists. PHP and the Department shall report to one another if they identify any provider as appearing on the Exclusion Lists in order to ensure that no payments are paid to a provider appearing such Exclusion Lists.

Program Integrity

The Department oversees required PHP program integrity activities through frequent communication and receipt of detailed reports of each PHP's compliance and program integrity activities. The Department conducts operational audits and data reviews of PHPs and providers and, through these activities, as appropriate, will share any information between PHPs regarding potential fraud, waste or abuse by providers or beneficiaries. The Department will require certain monitoring and auditing activities; PHPs will describe the specifics of those activities in their Fraud Prevention Plan. The Department will review credible allegations of fraud, while each PHP's Special Investigations Unit (SIU) is legally and contractually required to promptly refer those matters to the Department. Should the Department determine that fraud allegations appear credible, as required under federal regulation, the Department will refer the matter to the North Carolina Department of Justice Medicaid Investigations Division ("MID") or other law enforcement agencies for review. MID will evaluate the matter and determine whether it or the PHP should continue the investigation.

As noted in Appendix C, the Department performs a full review of the PHP's compliance program and program integrity activities at least every three years through its EQR process. On an annual basis, the Department performs tracer audits of each PHP to ensure that the PHP is following its Department-approved processes and Fraud Prevention Plan in carrying out its program integrity obligations.

While providing oversight and compliance auditing of the PHP fraud, waste and abuse efforts, the Department's Program Integrity unit will continue to provide mandated fraud, waste and abuse investigations and auditing for the fee-for-service services not transitioned to Medicaid managed care.

(C) Use of Sanctions

The State may impose any or all sanctions, including requiring a PHP to take remedial action, imposing intermediate sanctions and/or assessing liquidated damages, due to non-compliance with contract requirements or applicable federal or state law which includes, but is not limited to, a finding by the Department that a PHP acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the PHP is required to provide, under law or under the Contract with the State, to an enrollee covered under the Contract;
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to

discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

- Misrepresents or falsifies information that it furnishes to CMS or to the Department;
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210.
- Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information; or
- Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations.

Upon the discovery of non-compliance or a deficiency, the Department will assign the non-compliance or deficiency into one of four risk levels. The risk level assignment and the imposition of specific sanctions against a PHP will be commensurate with the non-compliance or deficiency, taking into consideration some or all of the following factors:

- The nature, severity, and duration of the violation;
- The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, or program integrity);
- Whether the violation (or one that is substantially similar) has previously occurred;
- The timeliness in which the PHP self-reports a violation;
- The PHP's history of compliance;
- The good faith exercised by the PHP in attempting to stay in compliance (including self-reporting by the PHP); or
- Any other factor that the Department deems relevant based on the nature of the violation.

V. Conclusion and Opportunities

Opportunities for Improvement In Data Collection and Measurement

Continuous assessment of progress against this Quality Strategy is not without challenges. As North Carolina Medicaid continues its transition from a predominantly fee-for-service model with PCCM model to a system of managed care, new roles and responsibilities will continue to create new processes and potential challenges for data collection. Currently, the Department's Medicaid data infrastructure leverages a combination of fee-for-service claims and encounter data from LME-MCOs, and a significant amount of the analysis and reporting of data to providers is managed through the Department's contract with its PCCM vendor. To manage utilization and improve outcomes through Medicaid managed care, the Department must collect and process encounter data from PHPs and integrate these data from plans with fee-for-service claims for carved-out populations and services.

To address potential challenges with the State's collection of encounter data, PHPs will be held accountable for submitting timely and accurate encounter data on a regular basis. PHP contracts provide guidance specifying the format, frequency, quality review, and other standards for encounter data submission, and specify incentives and financial penalties for plans to submit timely and accurate encounter data. The Department has systems to track the current portfolio of statewide quality measures, as described in Section I(B) and in Appendix A, both at the PHP level and at the practice level across PHPs. As additional measures

may be identified, including metrics that require the collection of data beyond that which is captured in claims and encounter data or described in this Quality Strategy, the Department will continue to work with stakeholders to enhance existing capabilities and/or develop new data collection processes and systems to accommodate these needs.

To enhance PHPs' and Medicaid providers' ability to improve the effectiveness and efficiency of care, the Department will explore opportunities to reduce the costs and complexity of data collection by: (1) creating consistent approaches to data collection and reporting, and (2) aggregating the collection of data from multiple sources into single, statewide systems.

Opportunities for Advancing the Quality of Care

In addition to implementation and assessment of the components of North Carolina's Quality Strategy, the Department looks forward to several opportunities to expand and build upon the Department's interventions to transform and drive quality improvements within its Medicaid managed care program. Key elements of this transformation and opportunities as the Department looks to the future include:

- Further refinement of the Quality Objectives outlined within this Quality Strategy, based on the identification of opportunities for improvement based on PHP and program-wide performance results in Year 1, and in order to mitigate health disparities;
- The continued integration of social determinants of health and addressing unmet resource needs in treatment planning, provision of services and improvements in overall health outcomes;
- Development of the State's Value Based Payment Roadmap, designed to build upon PHP advancements in the first two years of managed care; and
- Building upon the integration of behavioral health and physical health services, a key element of driving whole-person centered care forward.

Further, described throughout this Quality Strategy are requirements, standards, and protocols built to ensure the State, PHPs, the EQRO, and other key entities and stakeholders remain engaged in ongoing, active quality improvement efforts. For example: PHPs are required to report several Department-defined quality measures, including those in Appendix A; these measures will be assessed and validated by the EQRO, and the Department will work together with the EQRO, PHPs and other key experts and stakeholders to continually review progress on these measures, identify opportunities for improvement, and maintain the Quality Strategy as a living documentation of these efforts.

This Quality Strategy aligns the many Medicaid improvement efforts taking place in North Carolina – particularly the State's transition to managed care and the interventions described in Section II(C) – with the State's goal to build an innovative, whole-person, well-coordinated system of care, addressing both medical and non-medical drivers of health. The Quality Strategy recognizes the importance of continuous quality improvement, and the Department anticipates that, over time, modified Goals, Objectives, and Measures will be set forth in order to drive continued improvement against the greatest areas of opportunity and need. Further, this Quality Strategy – through several interventions and mechanisms described within – recognizes the importance of continued provider engagement and the value in building upon program successes. The Aims, Goals, Objectives and measures detailed in this Quality Strategy provide the framework for assessing

progress in quality improvement during its transition to managed care and in the context of the populations that will be included in that transition in the near-term, and will continue to evolve as part of the continuous quality improvement process.

Engagement and feedback are critical to the success of this Quality Strategy, to DHHS's quality efforts moving forward, and to Medicaid's transformation efforts broadly. The Department welcomes and encourages stakeholder comments on this initial Quality Strategy prior to its finalization, and on an ongoing basis as it is updated and the State conducts a continuous quality improvement process. The Department will continue to engage the Medical Care Advisory Committee (MCAC) and with beneficiaries, providers, plans, elected officials, local agencies, communities, and other stakeholders throughout the health care and social services systems to shape, implement and monitor Medicaid program changes – including on changes that relate to quality, the transition to managed care, and several other related topics.

Appendices⁵⁸

Appendix A: Priority Quality Performance Measures

PHPs are required to annually submit to the Department quality measures aligned to accreditation requirements, a subset of CMS Adult and Child Core measure sets, measures aligned to specific State interventions and programs, and measures identified by the Department as priority measures, as is further outlined in Section I(B).

This Appendix does **not** depict the full universe of quality measures that PHPs are required to report or may be required to report in the future; rather, it is intended to outline select, priority quality measures that will be used to assess disparities in care and to identify the subset of quality measures that will be publicly reported on NC DHHS’s website annually. Over time and as the continuous quality improvement process evolves, the Department will refine the measures required from PHPs, based on PHP performance over time, the evolution of national clinical standards, and North Carolina-specific opportunities for improvement.

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Objective 1.1: Ensure Timely Access to Care			
Getting Care Quickly NQF #: 0006	The survey asks enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed and allows the following response options: never; sometimes; usually; or always. <ul style="list-style-type: none"> • Q4: Respondent got care for illness/injury as soon as needed (or, for the Child Version: Child got care for illness/injury as soon as needed) • Q6: Respondent got non-urgent appointment as soon as needed (or, for the Child Version: Child got non-urgent appointment as soon as needed) 	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version	AHRQ
Getting Needed Care NQF #: 0006	The survey asks enrollees how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan and allows the following response options: never; sometimes; usually; or always.	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS	AHRQ

⁵⁸ This list of Priority Quality Performance measures are in draft form and will be finalized by the Department.

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
	<ul style="list-style-type: none"> • Q9: Easy for respondent to get necessary care, tests, or treatment (or, for the Child Version: Easy for child to get necessary care, tests, or treatment) • Q18: Respondent got appointment with specialists as soon as needed (or, for the Child Version: Respondent got child an appointment with specialists as soon as needed) 	Health Plan Survey 5.0H, Child Version	
Objective 1.2: Maintain Medicaid Provider Engagement			
Overall Provider Satisfaction with PHP	Survey asking providers' overall experience and satisfaction with PHP based on rating scale of PHP meeting the community providers' needs and expectations within the measurement period	EQRO: Standardized Provider Survey ⁵⁹	
Objective 2.1: Promote Patient Engagement in Care			
Rating of All Health Care NQF #:0006	<p>The survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best.</p> <ul style="list-style-type: none"> • Q8: Rating of all health care (or, for the Child Version: Q8: Rating of all health care) 	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version	-AHRQ
Rating of Personal Doctor NQF #:0006	<p>The survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best.</p> <ul style="list-style-type: none"> • Q16: Rating of personal doctor (or, for the Child Version: Q19: Rating of Personal Doctor) 	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version	-AHRQ
Objective 2.2: Link Patients to Appropriate Care Management and Care Coordination Services			
Customer Service NQF #:0006	<p>The survey asks enrollees how often customer service staff were helpful and treated them with courtesy and respect and allows the following response options: never; sometimes; usually; or always.</p> <ul style="list-style-type: none"> • Q22: Customer service gave necessary information/help (or, for the Child Version: Q25: Customer service gave necessary information/help) 	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version	AHRQ
Objective 2.3: Address Behavioral and Physical Health Comorbidities			

⁵⁹ The Department will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Objective 3.1: Promote Child Health, Development, and Wellness			
Childhood Immunization Status (Combination 10) NQF #: 0038	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	PHPs: Claims Data	NCQA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life NQF #: 1516	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	PHPs: Claims Data	NCQA
Immunizations for Adolescents (Combination 2) NQF #: 1407	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13 th birthday. The measure calculates a rate for each vaccine and two combination rates.	PHPs: Claims Data	NCQA
Percent of Eligibles Who Received Preventive Dental Services NQF #: 1334	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.	PHPs: Claims Data	CMS (collected via the CMS-416 form)
Objective 3.2: Promote Women's Health			
Cervical Cancer Screening NQF #: 0032	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women 21–64 years of age who had cervical cytology performed every 3 years • Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years 	PHPs: Claims Data	NCQA

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Prenatal and Postpartum Care (Both Rates) NQF #: 1517	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. <ul style="list-style-type: none"> • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. 	PHPs: Claims Data	NCQA
Live Births Weighing Less Than 2,500 Grams NQF #: 1382	The percentage of births with birthweight <2,500 grams	TBD: State Vital Records	CDC
Contraceptive Care: Postpartum NQF #: 2904	Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.	PHPs: Claims Data	US Office of Population Affairs
Contraceptive Care: Most & Moderately Effective Methods NQF #: 2903	The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception. The proposed measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.	PHPs: Claims Data	US Office of Population Affairs

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Pregnancy risk screening form ⁶⁰	The percentage of Non-Emergency deliveries with a completed standardized pregnancy risk screening within the measurement period	PHPs: Standardized Screening Tool ⁶¹	-
Objective 3.3: Maximize LTSS Populations' Quality of Life^{62 63}			
Objective 4.1: Improve Behavioral Health Care			
Follow-up After Hospitalization for Mental Illness NQF #: 0576	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.	PHPs: Claims Data	NCQA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates) NQF #: 0004	"The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit." •	PHPs: Claims Data	NCQA
Objective 4.2: Improve Diabetes Management			

⁶⁰ Administrative, financial, or process measure designed by the Department; Technical specifications currently under development

⁶¹ The Department will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

⁶² For additional information regarding the measures included for Objective 3.3, reference the National Quality Forum, "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement," September 2016. Available at:

http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living_Addressing_Gaps_in_Performance_Measurement.aspx

⁶³ The Department will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) NQF #: 0059	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	PHPs: Claims Data	NCQA
Objective 4.3: Improve Asthma Management			
Asthma Medication Ratio (Total Rate) NQF #: 1800	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	PHPs: Claims Data	NCQA
Objective 4.4: Improve Hypertension Management			
Controlling High Blood Pressure NQF #:0018	<p>The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:</p> <ul style="list-style-type: none"> • Members 18–59 years of age whose BP was <140/90 mm Hg • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg <p><i>Note: A single rate is reported and is the sum of all three groups.</i></p>	PHPs: Claims Data	NCQA
Objective 5.1: Address Unmet Resource Needs			
Rate of Screening for Unmet Social Needs ⁶⁴	The percentage of enrollees screened for unmet social needs form the health risk screening by the PHP within measurement period.	PHPs: Standardized Screening Tool ⁶⁵	-

⁶⁴ Administrative, financial, or process measure designed by the Department; Technical specifications currently under development

⁶⁵ The Department will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Objective 5.2: Address the Opioid Crisis			
Concurrent use of Prescription Opioids and Benzodiazepines	This measure examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines. The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids filled on 2 or more separate days, for which the sum of the days supply is 15 or more days during the measurement period. Patients in hospice care and those with a cancer diagnosis are excluded. The numerator includes individuals from the denominator with 2 or more prescription claims for benzodiazepines filled on 2 or more separate days, and concurrent use of opioids and benzodiazepines for 30 or more cumulative days.	PHPs: Claims Data	PQA
Objective 5.3: Address Tobacco Use			
Medical Assistance with Smoking and Tobacco Use Cessation NQF #: 0027	<p>The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:</p> <ul style="list-style-type: none"> • Advising Smokers and Tobacco Users to Quit. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. • Discussing Cessation Medications. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. • Discussing Cessation Strategies. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year. • 	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version	AHRQ
Objective 5.4: Reduce Health Disparities			
<i>Select measures in this Appendix are to be reported by select strata, including age, race, ethnicity, sex, primary language, and disability status and broken out, where possible, by key populations groups (e.g., LTSS) and geography</i>			
Objective 5.5: Address Obesity			

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Adult Body Mass Index (BMI) Assessment NQF #: 0023	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	PHPs: Claims Data	NCQA
Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (the total of all ages for each of the three rates) NQF #: 0024	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. <ul style="list-style-type: none"> • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	PHPs: Claims Data	NCQA
Objective 6.1: Ensure High Value and Appropriate Care			
Inpatient Utilization- General Hospital/Acute Care (IPU) NQF #: 1598	This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, medicine.	PHPs: Claims Data	NCQA
Total Cost of Care NQF #: 1604	This measure includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	PHPS: Claims Data	HealthPartners
Avoidable Emergency Department Utilization	This measure uses claims data to retrospectively assess which ED visits were likely preventable.	PHPs: Claims Data	NYU/Billings
Avoidable Inpatient Utilization (Adults)	This set of measures use hospital discharge data asses the quality of care for conditions that are likely affected by the care patients receive in ambulatory care settings.	PHPs: Claims Data	AHRQ
Avoidable Pediatric Utilization	This set of measures use hospital discharge data to assess potentially preventable complications in pediatric patients treated in hospitals, as well as preventable hospitalizations among pediatric patients.	PHPs: Claims Data	AHRQ

Appendix B: External Quality Review Organization (EQRO) Activities

As noted throughout this Quality Strategy, the External Quality Review Organization plays a critical role in reporting against PHPs' performance in several areas required by (meaning federal regulations require that these activities are completed by the EQRO), and optional (meaning that the State has elected to use the EQRO for these activities) under 42 CFR 438.352 and 438.364. A collective overview of these functions discussed throughout the Quality Strategy is included below.

Mandatory EQRO Activities
<ul style="list-style-type: none"> • Validation of performance improvement projects (PIPs) conducted by each PHP • Validation of each PHP's reported performance measures • Review of each PHP's compliance with the standards set forth in 42 CFR 438 Subpart D • Validation of PHP network adequacy⁶⁶ • Annual technical report that summarizes findings on access and quality of care, including the requirements set forth in 42 CFR 438.364.
Optional Activities
<ul style="list-style-type: none"> • Validation of encounter data reported by each PHP • Administration of the CAHPS Plan Survey and Provider Survey • Calculation of performance measures in addition to those reported by PHPs, at the direction of the Department or as required for completion of the technical and/or health equity report • Completion of studies on quality that focus on an aspect of clinical or nonclinical services at a point in time (e.g., specific assessment of the interventions described within this Quality Strategy), at the direction of the Department
Additional Activities
<ul style="list-style-type: none"> • Review, in conjunction with the requirements set forth in 42 CFR 438 Subpart D, of the requirements set forth by DHHS in PHP contracts • Technical assistance to PHPs as related to conducting PIPs, quality reporting, and accreditation preparedness, as directed by DHHS • Annual health equity report, assessing PHP and program-wide performance against select measures indicated in Appendix A based on select strata including age, race, ethnicity, sex, primary language, and a breakdown of measures for key population groups (e.g., LTSS) • Tracer audits of each PHP for program integrity

⁶⁶ Validation of network adequacy is required by 42 CFR 438.358(b)(iv), pending release of EQRO protocols related to this requirement. In the interim, the Department utilizes the EQRO for this function as an additional activity. Additional information can be found in this June 2016 CMCS informational bullet: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib061016.pdf>

Appendix C: Minimum Required Elements of PHPs' Annual Fraud Prevention Plans and Reports

PHP Fraud Prevention Plan Minimum Requirements

- The name of the Compliance Officer
- Description of the SIU, the roles within the SIU, and staffing by title
- Description of the SIU staff qualifications
- PHP's internal controls and policies and procedures that are designed to prevent, detect, and report known or suspected fraud and abuse activities
- The process and procedures to ensure that all suspected fraud and abuse reported in compliance with the Contract
- The process and procedure to ensure that all network provider terminations related to suspected or confirmed fraud and abuse, as well as PHP staff termination for engaging in prohibited marketing conduct are reported to the Department as required by the Contract
- Employee and contractor education on federal and state laws, as well as PHP practices for detection, identification, reporting and prevention of fraud, waste and abuse to ensure that the PHP's officers, directors, employees, contractors, network providers, and beneficiaries know and understand these obligations
- A description of the PHP's specific controls to detect and prevent potential fraud and abuse, including, without limitation:
 - A list of automated pre-payment claims edits
 - A list of automated post-payment claims edits
 - A list of desk audits on post-processing review of claims planned
 - A list of reports on network provider profiling used to aid program and payment integrity review
 - The methods PHP will use to identify high-risk claims and PHP's definition of "high-risk claims"
 - Visit verification procedures and practices, including sample sizes and targeted provider types or locations
 - A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services
 - Policies and procedures used by the PHP designed to prevent, detect, and report known or suspected fraud and abuse activities
 - A list of references in provider and enrollee material regarding fraud and abuse referrals (e.g. on member EOB)
 - Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly
 - The process by which the SIU shall monitor PHP's marketing representative activities to ensure that the PHP does not engage in inappropriate activities, such provision of inducements
- Assurance that the identities of individuals reporting violations of by the PHP are protected and that there is no retaliation against such persons
- Describe criminal background exclusion screening process for its owners, agents, employees, network providers, and subcontractors

Annual PHP Fraud Prevention Report Minimum Requirements

- The name of the PHP
- The name of the person and department responsible for submitting the Fraud Prevention Report
- The date the report was prepared
- The date the report is submitted

Annual PHP Fraud Prevention Report Minimum Requirements	
	<ul style="list-style-type: none"> Name of persons who have SIU responsibilities, as well as the name of the Compliance Officer
	<ul style="list-style-type: none"> A list of activities planned but not performed under the approved Fraud Prevention Plan and the reason(s) for non-performance.
	<ul style="list-style-type: none"> The results of the activities performed pursuant to the approved Fraud Prevention Plan and any additional similar activities performed which were not included in the Fraud Prevention Plan, including trainings provided
	<ul style="list-style-type: none"> A summary spreadsheet of each audit, on-site review or other activity containing the following: <ul style="list-style-type: none"> Insert the PHP case number, if any Insert the NPI(s) of the providers subject to the review or activity and name(s) of the providers. Insert the dates when the audit, review or activity commenced and when it was completed. Insert the activity type: Audit, Self-Audit, Investigation, and Review. "Audit" is defined as a PHP performing provider monitoring or audit of a group of Providers; "Self-Audit" is defined as a provider conducting its own QA and identifying/self-disclosing billing anomalies, discrepancies, or overpayments; An "Investigation" is defined as a case initiated by a lead, referral, complaint and/or FAMS data analytics reports; a "Review" is defined as any other activity that lead to the information, such as grievance or appeal. Insert a brief statement about the concern, allegation or complaint Insert findings or requests associated with the allegation or complaint. Refrain from using 'substantiated' or 'unsubstantiated' as the only finding statement. Identify the payback amount/overpayment amount, if any. Identify if an appeal was provided and the results, including overpayment amount, if any. Identify the amount recouped by the PHP, if any Identify the remaining amount owed to PHP, if any Insert the date received the allegation or complaint as the Open date Insert the date the all action on the case has been exhausted and/or final determinations has been rendered with the exception of referrals sent to PI for the closed date Indicate if the matter was referred to PI for potential fraud. Include any additional comments related to the case, provider, or additional administrative actions taken. Also, include if the activity was completed outside the SIU.
	<ul style="list-style-type: none"> List any providers subject to prepayment review, the length of any such review, and the outcome
	<ul style="list-style-type: none"> A description of any predictive modeling used